DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 654-8076

February 21, 2001

MMCD All-Plan Letter No. 01002

TO: Medi-Cal Managed Care Health Plans

SUBJECT: REPORTING AND OTHER REQUIREMENTS REGARDING WORKERS' COMPENSATION RECOVERY

PURPOSE:
The goal of this letter is to set forth and clarify reporting and reimbursement requirements for Medi-Cat managed care plan (MCP) contractors when a Medi-Cal beneficiary claims a work-related injury and the services related to that injury are provided by a MCP.

DEPARTMENT RECOVERY RIGHTS:
The Department of Health Services retains lien/claim rights in workers' compensation matters involving Medi-Cal members pursuant to Welfare and Institutions Code Sections 14124.70-I 4124.791.

Boehm and Associates (Boehm) is the contractor acting on behalf of the Department in workers' compensation cases.

WORK RELATED INJURIES:
When a beneficiary asserts that an injury was work related, but the workers' compensation carrier disputes the injury, the beneficiary may file a claim with the Workers' Compensation Appeals Board (WCAB). In these instances the Department, through Boehm, will file a claim with the WCAB. However, if the carrier does not dispute the injury, the workers' compensation insurance carrier may reimburse the provider of the service directly. If the insurance carrier reimburses the provider, the provider is not allowed to retain the Medi-Cal payment, and must return the funds to the Department in order to avoid duplicate payments.

CONTRACTOR RESPONSIBILITIES RE WORKERS' COMPENSATION CLAIMS:
Often the MCP contractor will be the first to receive notice of a possible workers' compensation claim when the beneficiary seeks treatment for the work-related injury. All MCP contracts require that contractors identify and notify the Department within 10 days of the discovery of any case in which an action by a Medi-Cal beneficiary involving the tort liability of a third party could result in recovery by the recipient of funds to which the Department has lien rights pursuant to the Welfare and Institutions

Code sections set forth above. In those cases where Boehm receives notification of a possible claim they will notify the MCP by requesting an itemization of medical services provided to the MCP member.

Tort liability actions include, but are not limited to, workers' compensation actions. The Department's lien rights extend to the MCP contractor's subcontractors; therefore all contracts entered into between the MCP contractor and its subcontractors should include a provision setting forth that the Department retains sole lien/claim rights in these cases.

Unlike personal injury cases, where the MCP contractor is required to contact the Department directly, when a MCP contractor provides services for Medi-Cal beneficiaries who claim a work-related injury, the MCP contractor should notify Boehm directly. Secondly, the MCP contractor shall obtain the following information by direct questioning of the injured member, or the member's parent, spouse, and/or guardian:

1) Member name
2) Address
3) Social Security Number
4) Telephone Number
5) Date of Injury
6) Type of injury
7) Attorney's name, address, and telephone number (if applicable)
8) Insurance Company name, address, and telephone number (if applicable)
9) Employer's name, address, and telephone number

Once this information is obtained the MCP contractor shall prepare an itemized list of all services provided to the member from the date of the injury forward. This itemized list (including out-of-plan services) must include the following information for each service:

1) Date(s) of service
2) Provider name (if different from the contractor)
3) Diagnosis code
4) Procedure description/procedure code
5) Value of services (usual, customary, and reasonable charges made to the general public)
6) Date of denial and reasons (if applicable)
7) Medi-Cal allowable amount (if applicable)
8) Amount billed by a subcontractor or out-of-plan provider (if applicable)
9) Amount and date paid by contractor to subcontractor or out-of-plan provider (if applicable)

If treatment will be ongoing, the MCP contractor must note this in the comment portion of the itemization and update this information as necessary. This information is required pursuant to the terms of the MCP contract and the California Code of Regulations, Title 22, and Sections 53861 and 53862. Once compiled, reports regarding workers' compensation are to be mailed to:

Boehm and Associates
P.O. Box K
Alameda, CA 94501

In the event a MCP contractor 'is contacted by a Medi-Cal member, the member's attorney or a workers' compensation carrier, requesting an itemization. for a workers' compensation claim, the MCP contractor shall direct these individuals to Boehm. Boehm's phone number is (510) 865-0544. Questions relating to reporting requirements should be directed to Joan Mitchell, Workers' Compensation Contract Specialist, at (916) 323-9698.

In the event a MCP contractor is contacted by Boehm or the Department requesting an itemization of medical services provided to a MCP member, the MCP contractor is responsible for forwarding the itemization to Boehm within 30 days of the date of the request.

REDUCING THE RISK OF DUPLICATE PAYMENTS:

The terms of the MCP contracts preclude MCP contractors from recovering duplicate payment for services provided to Medi-Cal beneficiaries. Accordingly, MCP contractors are required to comply with all of the contractual reporting requirements set forth in this letter.

In cases where the workers' compensation carrier does not dispute the injury, the carrier may improperly reimburse the provider of the service directly. In the event a provider or a MCP contractor receives payment from a workers' compensation carrier for treatment of a work-related injury, and the MCP contractor had not previously notified Boehm of the services related to a work-related injury, the MCP is required to follow the procedure set forth above describing the MCP's responsibilities with respect to workers' compensation claims. Once that data has been obtained, the itemization,

along with reimbursement for any payments received from the workers' compensation carrier, should be sent to:

Department of Health Services
Program Analysis Unit
P.O. Box 2471
Sacramento, CA 95812-2471

Payments received from workers' compensation insurance carriers after the MCP has notified Boehm of the services for a work-related injury should also be sent to this address.

If you have any questions, or need additional information or clarification, please contact your contract manager.

Cheri Rice

Cheri Rice, Chief
Medi-Cal Managed Care Division

bcc: Ms. Linda Minamoto
Associate Regional Administrator
Health Care Financing Administration
Division of Medicaid
75 Hawthorne Street, Fifth Floor
San Francisco, CA 941053903

Mr. Byron Chell
Executive Director
CA Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

Kevin Aslanian
C.C.W.R.O.
1901 Alhambra Blvd.
Sacramento, CA 95816

Lorraine Brown
Deputy Director
Benefits & Quality Monitoring
Medical Risk Management Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95815

Carol Freels, Acting Chief
Office of Long Term Care
1800 3rd Street, Suite 205
Sacramento, CA 95814

Robert P. Pierson, Chief
Office of Medi-Cal Dental Services
7667 Folsom Blvd., Suite 101
Sacramento, CA 95816

Joan Allison, Chief
Third Party Liability Branch
Payment Systems Division
591 North 7'" Street
Sacramento, CA 95814

James Dandridge, Chief
Medical Review Branch
Audits and Investigations
591 No. 7th Street
Sacramento, CA 95814

Jerry Stanger, Chief
Payment Systems Division
8/950

Maridee Gregory, M.D., Chief
Children's Medical Services Branch
Primary Care & Family Health Division
8/350

Cheri Rice, Chief
Medi-Cal Managed Care Division
8/650

Vickie Orlich, Acting Chief
Policy & Program Development Branch
Medi-Cal Managed Care Division
8/650

Barry E. Handon, M.D., M.P.H.
Acting Chief
Office of Clinical Standards and Quality
Medi-Cal Managed Care Division
8/523

Mickey Richie
Local Liaison
Executive Off ice
8/1 253

Steve Soto, Acting Chief
Plan Management Branch
Medi-Cal Managed Care Division
8/1 400

Bacilio Garcia
Acting Chief
Plan Monitoring/Member Rights Branch
Medi-Cal Managed Care Division
8/650

Acting Chief
Headquarters Management Branch
Payment Systems Division
8/950

Acting Chief
Medi-Cal Operations Division
600 North 10th St., Suite 230C
Sacramento, CA 95814

Ted Spelis
Acting Chief
Health Care Options Section
Payment Systems Division
8/950

Roberto Martinez
Acting Chief
Medi-Cal Policy Division
8/1561

State of California

Department of Health Service

Memorandum

Date : January 25, 1999

To : Barbara Hooker, Chief
Payment Systems Division
714 P Street, Room 950

From : Office of Legal Services
714 P Street, Room 1216
(916) 653-9164

Subject : Legal Opinion: Exemptions to Prohibitions Against Contracting Personal Injury Recoveries to Managed Care Plans

BACKGROUND

Welfare and Institutions Code section 14 124.70 requires the Department of Health Services (Department) to identify and recover Medi-Cal funds from liable third parties. This responsibility includes the filing of, and collecting on, liens in personal injury actions involving Medi-Cal beneficiaries.

The Department is considering delegating the personal injury recovery function to the various Medi-Cal managed care plans via contract.

Although Welfare and Institutions Code section 14019.3 requires a Medi-Cal provider to accept Medi-Cal as payment in full, the Department would assign the plan the Department's right to actual plan recoveries. For plans at risk, the assignment would be capped at the risk limit. The Department would retain the right to prosecute its own recovery of, and retain, expenditures in excess of that limit. In return for the assignment of actual recoveries, the Department would reduce a plan's capitated rate by an amount equal to historical fee-for-service recoveries per beneficiary rather than by actual recovery amounts. Eventually, capitation rate per-capita reductions would be based on the plan's actual recovery history. To the extent the plan's recoveries exceed the capitated rate offset amounts, the plan would be enriched. To the extent that the plan's recoveries were less, the plan would be at risk.

The Department intends to let the plan retain its own counsel, presumably by subcontract, without becoming a signatory to or requiring prior Attorney General review and approval of the subcontract.

In a medical malpractice case, a managed care contractor could be a defendant as well as a lienholder.

Article VII of the California Constitution, it is highly unlikely any attempted exemptions would survive a legal challenge. (California State Employees Association v. State (1988) 199 Cal.App.3d 840.) Simply stated, and as is discussed in greater detail below, a statute cannot change the constitution, it must comply with it.

To begin, managed care legislation exempts the director from compliance with Public Contract Code provisions in negotiating Managed Care Plan Contracts.[1] It also authorizes non-traditional methods of reimbursing plans[2] for providing services to Medi-Cal beneficiaries. However, Public Contract Code sections 10335 through 10354 govern "all contracts for *services* to be rendered to the state...." (Pub. Con. Code, § 10335). The recovery services are services rendered to the state within the meaning of that statutory scheme rather than services to beneficiaries within the meaning of the managed care legislation. Additionally, according to rules of statutory construction: the specific prevails over more general language. (Code of Civ. Pro. § 1859.[3] See also Estate of Stake v. Wells Fargo Bank (1998) review denied July 22, 1998, 63 Cal.App.4th 396.) There is a specific statutory scheme which requires that the Department perform the recovery function. This specific scheme prevails over the more generic provisions for contracting out managed care services, especially in light of the requirements of section 19130 and Article VII of the California

[1] Welfare and Institutions Code section 14087.3 authorizes the director to contract "on a bid or nonbid basis" with Managed Care Plans. Contracts entered into pursuant to Article 2.7, commencing with section 14087.3, are exempt from the provisions of Chapter 2 (commencing with §10290), Part 2 of Division 2 of the Public Contract Code but must be reviewed by the Department of Finance. (Welf. & Inst. Code § 14087.4.)

[2] Section 14087.3(a)(3) authorizes the Department to "[p]rovide for alternate methods of payment, including...capitation, shared savings, volume discounts, lowest bid price, negotiated price, rebates, or other basis". Section 14087.3(a)(4) authorizes the director to "[s]ecure services directed at...(B) [d]esigning and implementing fiscal or other incentives for providers to participate in the Medi-Cal program in cost-effective ways (C) [l]inking beneficiaries with cost-effective providers". Section 140087.3(a)(5) authorizes the director to "[p]rovide for: (A) Medi-Cal managed care plans contracting under this chapter or Chapter 8 (commencing with Section 14200) to share in the efficiencies and economies realized by those contracts...." Section 14087.3(c) directs the Department to "seek federal waivers necessary to allow for federal financial participation under this section".

[3] Section 1859 states: "In the construction of a statute, the intention of the legislature .... is to be pursued, if possible; and when a general and particular provision are inconsistent. the latter is paramount to the former. So a particular intent will control a general one that is consistent with it."

sources and must be accompanied by a Request for Exemption From Contract Advertising Form STD 821 signed by a deputy director. DGS must determine that a sole source contract is in the State's best interests.

Additionally, the law generally requires state agencies to use the Attorney General as their court representative. Except as specified, recovery law specifically requires it. Welfare and Institutions Code section 14124.71 (a) states:

> "[T]he director shall have a right to recover from [a tortfeasor or insurance carrier] the reasonable value of benefits so provided. The Attorney General, or counsel for the fiscal intermediary under the Medi-Cal program with the permission of the Attorney General, or a contractor pursuant to section 14124.80, or a county through its civil legal adviser, may, to enforce such right, institute and prosecute legal proceedings against the third person or carrier who may be liable for the injury in an appropriate court, either in the name of the director or in the name of the injured person...."

This statute specifically expresses the Legislature's desire to strictly control the circumstances under which someone other than the Attorney General is authorized to enforce the director's recovery rights. It does not authorize the Director or the Department to delegate a private managed care contractor, or its counsel, the authority to recover on the Director's behalf. Thus, notwithstanding any more general laws to the contrary, no duty or right to recover on any claim which requires legal proceedings may be given to managed care plan contractors or their attorneys without amending this statute.

Finally, no agency may contract for legal services without the Attorney General's prior authorization. That consent must be -obtained from the Attorney General before seeking DGS approval of the contract or any amendment. (Gov. Code § 11040 et seq.; State Contract Manual § 3.7 (revised 10/98).) Since the contract would authorize the plan to seek legal representation, the Attorney General must prior authorize the transfer of its function and the terms under which it will allow someone else to perform it.

QUESTION 2

Does the Department have the statutory authority to allow the provider to collect the value of Medi-Cal services and still keep the Medi-Cal capitated payment for those services?

ANSWER AND ANALYSIS 2

No. The Department only has the authority to do what the Legislature has authorized it to do. The Legislature has specifically restricted provider reimbursement in third party liability

California constitution which requires the Governor or his delegatees to perform the executive function. As stated in 71 Ops.Cal.Atty. Gen. 266 (1988):

> "... [A] public agency may not, unless authorized by law, delegate a function constituting a public trust the exercise of which inescapably requires the use of such reason and discretion as may only be accomplished by action of the agency itself. (Cf. Webster v. Board of Education (1903) 140 Cal. 33 1; Knight v. City of Eureka (18.98) 123 Cal. 192, 194-195; 63 Ops.Cal.Atty. Gen. 240, 243 (1980).)...." (Id. at page 267.)

The recovery function involves numerous discretionary activities: compromising a lien amount, declining to assert a lien if not cost-effective or if to do so would work a hardship on the beneficiary, etc. Accordingly, we recommend that you seek a statutory amendment authorizing the delegation of the recovery function before you proceed.

QUESTION 5

Would transferring the recovery function and allowing managed care providers to bill for the reasonable value of services provided to Medi-Cal enrollees jeopardize federal financial participation?

ANSWER AND ANALYSIS 5

Yes. As a condition to federal financial participation, a State's Medicaid program must submit a state plan which provides that the State 'take all reasonable measures to ascertain the legal liability of third parties, obtain approval of a plan for' pursuing claims against third parties and seek reimbursement of Medi-Cal payments from those third parties where cost effective. (42 U.S.C. § 1396a(a)(25).) A State's plan must require that Medicaid beneficiaries "assign the State any rights... to support... and to payment for medical care from any third party." 42 U.S.C. section 1396k(a)(1)(A); 42 U.S.C. sections 1396a(a)(45), 1396k(a)(1)(B). According to 42 C.F.R. section 433.138(d)(4)(ii), the Medicaid single state agency must secure agreements (to the extent State law permits) enabling access to State Motor Vehicle accident report files and keep that data confidential in accordance with 42 C.F.R. Part 431, subpart F. Absent waivers, the state agency must seek reimbursement from the third party to the limit of legal liability within 60 days after the end of the month in which payment is made. 42 C.F.R. section 433.139(d).

42 U.S.C.A. section 1396k(b) states:

> "such part of any amount collected by the State under an assignment [of a beneficiary's right to payment from a third party]...shall be retained by the State as is necessary to reimburse it for medical assistance payments made on

ATTACHMENT TO LEGAL OPINION RE TRANSFER OF PERSONAL INJURY RECOVERY FUNCTION

Government Code section 19130, as relevant to this opinion, provides as follows:

a) Personal services contracting is permissible to achieve cost savings when all the following conditions are met:

"(1) The contracting agency clearly demonstrates that the proposed contract will result in actual overall cost savings to the state, provided that:

"(A) In comparing costs, there shall be included the state's additional cost of providing the same service as proposed by a contractor. These additional costs shall include the salaries and benefits of additional staff that would be needed and the cost of additional space, equipment, and materials needed to perform the function.

"(B) In comparing costs, there shall not be included the state's indirect overhead costs unless these costs can be attributed solely to the function in question and would not exist if that function was not performed in state service. Indirect overhead costs shall mean the pro rata share of existing administrative salaries and benefits, rent, equipment costs, utilities, and materials.

"(C) In comparing costs, there shall be included in the cost of a contractor providing a service any continuing state costs that would be directly associated with the contracted function. These continuing state costs shall include, but not be limited to, those for inspection, supervision, and monitoring.

"(2) Proposals to contract out work shall not be approved solely on the basis that savings will result from lower contractor pay rates or benefits. Proposals to contract out work shall be eligible for approval if the contractor's wages are at the industry's level and do not significantly undercut state pay rates. "(3) The contract does not cause the displacement of civil service employees.... . . . .

"(5) The savings shall be large enough. to ensure that they will not be eliminated by private sector and state cost 'fluctions that could normally be expected during the contracting period.

"(6) The amount of savings clearly justify the size and duration of the contracting agreement.

"(7) The contract is awarded through a publicized, competitive bidding process....

....

"(9) The potential for future economic risk to the state from potential contractor rate increases is minimal....

....

"(11) The potential economic advantage of contracting is not outweighed by the public's interest in having a particular function

3rd Party - TPL

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY

PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES

7141744 P STREET
P. 0. Box 942732
SACRAMENTO, CA 94234-7320

(916) 654-8076

January 29, 1997

Mr. Mark Sektnan
Legislative Advocate
California Association of HMOs, Inc.
1201 K Street, Suite 750
Sacramento, CA 95814

Dear Mr. Sektnan:,

Thank you for your letter of August 21, 1996, concerning problems presented by dual eligibles in the Medi-Cal managed care program. I apologize for the delay in responding to your questions.

The Department of Health Services' Third Party Liability Branch (TPL) has begun tracking Medi-Cal beneficiaries who are enrolled in Medicare health maintenance organizations (HMO). The letter (enclosed with your August 21 letter) sent to dual eligibles correctly describes the procedures to be followed by beneficiaries enrolled in a Medicare HMO, in order to obtain Medi-Cal covered services through the Medi-Cal Fee-For-Service (FFS) program. This letter reflects federal and State requirements for obtaining coverage for services covered by Medicare and services covered by Medi-Cal. The TPL Branch did not realize at the time they drafted this letter that there are dual eligibles enrolled in Medi-Cal managed care plans. The Medi-Cal Managed Care Division (MMCD) did not participate in the preparation of this letter.

Dual eligibles who join a Medicare HMO do not lose their Medi-Cal eligibility unless they do not report. their "other health coverage" to their county eligibility worker. State and federal law requires Medi-Cal providers to bill the other health coverage before billing the Medi-Cal program, and the State may stop the beneficiary's Medi-Cal benefits if the other health coverage is not reported. Dual eligibles retain the right to receive Medi-Cal covered services that are not covered by Medicare through the Medi-Cal FFS program or a Medi-Cal managed care plan. Dual eligibles are required to present both their Medicare HMO card and their Medi-Cal Benefits Identification Card (BIC) to a provider (Medicare or Medi-Cal) prior to receiving services. The BIC will inform the Medicare HMO of the beneficiary's Medi-Cal eligibility and enrollment, if any, in a Medi-Cal managed care plan.

The TPL Branch letter to beneficiaries states that payment by the Medi-Cal program for an out-of-plan service rendered to a Medicare HMO enrollee without prior approval depends on whether or not the service provided is covered by the Medicare HMO. If the service is covered by Medicare and available through the Medicare HMO, then Medi-Cal will not pay an out-of-plan (non-Medicare HMO) provider for that service. The Medi-Cal

program may deny payment of a coinsurance/deductible claim for a dual eligible when the beneficiary goes to an outside Medicare provider for a Medicare service that could have been obtained within the Medicare HMO, without a coinsurance/deductible payment required from Medi-Cal. Medi-Cal is the payor of last resort by law.

This policy also applies to a Medi-Cal managed care plan providing services covered by a Medicare HMO to a dual eligible enrolled in both plans. In this situation, the Medi-Cal managed care plan provides Medi-Cal services that are covered by the managed care plan and not covered by the Medicare HMO. The Department provides the Medi-Cal managed care plan with the "Prepaid Health Plan Address Master File:" This file indicates Medicare Part A and Part B eligibility for each Medi-Cal beneficiary, and whether or not the dual eligible is enrolled in a Medicare HMO. The plan should refer the beneficiary to the Medicare HMO for Medicare covered services or, in some cases, bill the Medicare HMO for Medicare covered services rendered by a plan provider. If the Medicare HMO denies the claim, the plan can bill through the Medi-Cal FFS program or pay for the service, if the service is not a Medicare covered service and is a covered Medi-Cal service under the plan's contract. Current Medi-Cal managed care plan enrollment data indicates that there are a number of dual eligibles enrolled in Medi-Cal managed care plans who are also members of Medicare HMOs.

The Department is currently writing a contract amendment to clarify its policy regarding dual eligibles in the Two-Plan Model managed care plans. The Two-Plan Model federal waiver requires dual eligibles in mandatory aid codes to enroll in the Local Initiative (LI) or the Commercial Plan (CP), unless they are enrolled in a Medicare HMO. Dual eligibles who choose to obtain Medicare benefits through a Medicare HMO may not, enroll in an LI or CP. This policy has been adopted to address case management and continuity of care issues. The only exception to this policy will be when a Medicare HMO is the prime contractor, i.e., the LI or CP, under the Two-Plan Model waiver and the Department specifically allows the Medicare HMO's current dual eligible enrollees to join the Two-Plan Model plan during the rollover process. The Department expects to require LIs or CPs that are also Medicare HMOs to negotiate a "wrap-around" Medi-Cal rate to accommodate Medi-Cal beneficiaries enrolled in the same HMO for both Medicare and Medi-Cal covered services, under separate contracts with the Medicare and Medi-Cal programs. The Two-Plan Model contractors will not be allowed to enroll any additional Medicare HMO members into the LI or CP until the wrap-around rate is negotiated and placed into the plan's Medi-Cal contract.

The Medicare program currently allows mid-month disenrollments and the Medi-Cal program processes all disenrollments effective the first of the month. As long as the two programs maintain these procedures there will be short-term coordination problems for

beneficiaries and providers. The Medi-Cal managed care program is not in the position at this time to change its regulations and contract language that prescribe disenrollment timeframes.

I am enclosing a letter (See Enclosure I) concerning the enrollment of foster care children and children in the Adoptions Assistance program that was sent to all County Welfare Directors in mid-January. This letter describes the Department's policy regarding foster care children that are eligible under foster care and non-foster care aid codes. An All-Plan Policy Letter discussing the same issues will be issued soon.

Supplemental Security Income/State Supplementary Payment (SSI/SSP) eligible individuals are voluntary enrollees for the Two-Plan Model program. The only time the mandatory enrollment process could create a problem for this group of beneficiaries is when they are in a mandatory enrollment aid code and their SSI/SSP eligibility is pending, and is then approved. Under these circumstances, such beneficiaries could be mandatorily enrolled prior to approval of their SSI/SSP application. After SSI/SSP status is approved, these beneficiaries may disenroll from the LI or CP at any time.

The Department's new enrollment contractor, Maximus, has replaced Benova, effective January 1, 1997. Plans may use the toll-free number, which has not been changed, in their advertising, for beneficiary access to enrollment information. Plans should still advise members and prospective members to call the plan's customer service number for plan-specific information. The Department is working with Maximus to assure that the problems experienced by Benova are not repeated and the transition of enrollment responsibilities is as smooth as possible.

Current members of health plans that are affiliated with either the LI or the CP in a Two-Plan Model region will be mailed an enrollment packet according to the approved implementation schedule for each Two-Plan Model region. Members of affiliated plans will be given the choice of staying with their current provider as a subcontractor of the LI or CP, enrolling in the other plan (if it is operational), or receiving benefits through the Medi-Cal FFS program with a specified provider (depending on the status of the other plan and whether or not the member is in a mandatory or voluntary aid code). Any member not making a choice will be rolled into the plan which has a subcontract with his/her current plan. A member of an affiliated plan could request an enrollment packet before the scheduled rollover and choose to change plans, but would not be defaulted into a plan at that time. Current mandatory aid code members of Medi-Cal managed care plans that are not affiliated with either the LI or CP will be required to choose one of the Two-Plan Model plans. If a beneficiary does not make a choice, he/she will be assigned to the LI or CP. The contracts

for existing plans not affiliated with the LI or CP will be terminated according to the implementation schedule for each Two-Plan Model region.

Newly determined eligibles and members of existing Medi-Cal managed care plans that have other health coverage identified by the County Eligibility Worker by the following coverage codes will not be allowed to enroll in the LI or CP and will be provided Medi-Cal benefits through the Medi-Cal FFS program: "K", where the member has Kaiser HMO coverage through a private payor and Kaiser is primary; "C", where the member has CHAMPUS Prime HMO coverage through a private payor and CHAMPUS is primary; "P", where the member has other HMO/Prepaid Health Plan coverage (not Kaiser, CHAMPUS or Medicare); and "F", where the member is eligible for both Medicare and Medi-Cal, Medicare is primary, and Medicare coverage is through a Medicare risk HMO (unless the LI or CP is a Medicare HMO contractor and conditions described above are met).

The Department has been made aware of the health plans' need to know which beneficiaries have been defaulted into a plan, for the purposes of quickly assigning a primary care physician. The Department will shortly begin providing this information to the plans.

The language you forwarded from the Health Care Financing Administration (HCFA) states that the State and the Medi-Cal health plans should coordinate delivery of Medicaid services with the Medicare delivery system chosen by a dually eligible beneficiary. The Department has several programs through which dual eligibles can receive full payment of Medicare premiums, coinsurance, and deductibles. Information on these programs is distributed to Medi-Cal beneficiaries in the Medi-Cal booklet (See Enclosure II) by the county welfare offices. Enclosed are examples of the information that is sent to Medi-Cal beneficiaries concerning dual eligibility (See Enclosures III and IV).

When a dual eligible chooses to receive Medi-Cal benefits through a Medi-Cal managed care plan, the coordination of care will be the responsibility of the Medi-Cal managed care plan. Medi-Cal managed care plans are authorized to recover and retain the cost of covered services provided to a plan member under the Medi-Cal contract to the extent that the member is covered for such services under any other state or federal medical care program, including Medicare. Medi-Cal contract requirements describe the procedures for such recoveries from third party payors.

If a dual eligible is receiving Medicare benefits through a Medicare HMO and is enrolled in a Medi-Cal managed care plan (other than a Two-Plan Model plan), the two plans need to communicate with each other to coordinate the beneficiary's health care. Asking to see both a Medicare HMO card and the BIC will allow each plan to establish the dual

eligibility of a beneficiary. The enclosed Information Notice (See Enclosure IV) instructs beneficiaries to tell each provider they see that they are seeing other providers. Such communication will help the plans to coordinate care for the beneficiary.

Medi-Cal beneficiaries receive a Medi-Cal booklet that explains Medi-Cal benefits, including benefits not covered by Medicare. Normally, Medi-Cal providers handle all the billing procedures for providing Medicare and Medi-Cal services in the Medi-Cal managed care plan setting. The beneficiary needs only to inform the plan that he/she is eligible to receive benefits from both programs.

I hope this information has answered your questions regarding dual eligibles and the mandatory enrollment feature of the Two-Plan Model. If you need more information or have additional questions, please contact Mr. Alan Stolmack, Chief of the Policy Support and Development Section, at (916) 653-5277 or Ms. Lisa Tanaka, Chief of the Policy Unit, at (916) 657-3204.

Sincerely,

Joseph A. Kelly, Chief
Medi-Cal Managed Care Division

Enclosures

cc: Ms. Joan Allison, Chief
Financial and Member Services Branch
714 P Street, Room 600
Sacramento, CA 95814

Mr. Ken Wagstaff, Chief
Expansion/Operations Branch I
714 P Street, Room 650
Sacramento, CA 95814

Mr. Ruben R. Gonzalez, MS., M.P.H., Chief
Expansion/Operations Branch II
714 P Street, Room 640
Sacramento, CA 95814

Mr. Michael Neff
Acting Chief
Health Care Options Transition
714 P Street, Room 1340
Sacramento, CA 95814

bcc: Ann-Louise Kuhns
Assistant Chief
Medi-Cal Managed Care Division
8/650

Mary Fermazin, M.D., MPA, Chief
Policy and Quality Improvement Branch
8/650

Alan Stolmack, Chief
Policy Support and Development Section
8/650

Byron Moss, Chief
Financial/Administrative Section
1801 7th Street

Lisa Tanaka, Chief
Policy Unit
8/640

Vickie Orlich, Chief
Financial Unit
1801 7th Street, 1st Floor

Craig Miller, Chief
Health Care Options Unit
8/1400

MC:sdw

MMCD # 885

PSDS # 256

Author: Maureen Childs, Analyst
Policy Unit
8/646 7-0676

Division: Joseph A. Kelly, Chief
Medi-Cal Managed Care
8/650 4-8076

WP 6.0 W:\CLERICAL\PQIB\MMCD885.96

Enclosure I

STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P street
Box 942732
Sacramento, CA 94234-7320
(916) 667-2941

January 13, 1997

TO: All County Welfare Directors
All County Medi-Cal Program Specialists/Liaisons
All County Chief Probation Officers
All Public/Private Adoption Agencies
All Department of Social Services District Adoptions Offices

Letter No.: 97-02

PARTICIPATION OF FOSTER CARE AND ADOPTION ASSISTANCE PROGRAM CHILDREN IN MEDI-CAL MANAGED CARE

SUMMARY

The purpose of this letter is to notify you of the Department of Health Services' (DHS) policy regarding Medi-Cal managed care enrollment of children who are under the supervision of county foster care or adoption agencies or any other agency identified in Eligibility and Assistance Standards Manual, Section 45-202.6 or 45-203.5, in the 14 California counties in which the Medi-Cal program is establishing a Medi-Cal "Two-Plan Model" managed care program or another Medi-Cal m&aged care program. Under these managed care programs, most family linked Medi-Cal beneficiaries are required to enroll in a managed care plan to receive their Medi-Cal benefits.

The policies contained in this letter impact children and youth in out-of-home care under the care and custody of county welfare and probation departments, and licensed private adoption agencies as well as children and youth with Adoption Assistance Program (AAP) benefits. This letter does not apply to children in out-of-home care under other circumstances.

The recently enacted budget bill, Senate Bill 1393 (Chapter 162, Statutes of 1996), contains language that allows the voluntary enrollment of children in foster care into managed care plans in the Two-Plan Model and geographic managed care (GMC) counties. The DHS has extended this policy to children in the AAP. Although the provisions of the budget bill will expire on June 30, 1997, it is the intent of the DHS that voluntary enrollment of foster children continue after June 30, 1997, until such time that the DHS has sufficient information that foster children placed out of county can easily receive needed medical care.

DESIGNATED COUNTIES

The Medi-Cal "Two-Plan Model" managed care program, or a similar managed care arrangement, is being established by the DHS in the following designated counties:

Alameda	Los Angeles	San Diego	Stanislaus
Contra Costa	Riverside	San Francisco	Tulare
Fresno	Sacramento	San Joaquin	
Kern	San Bernardino	Santa Clara	

This letter does **not** apply to County Organized Health Systems (COHS): Orange, Solano, San Mateo, Santa Cruz, and Santa Barbara Counties. Enrollment will continue to be mandatory and automatic for Medi-Cal beneficiaries, including foster and AAP children, in these counties. There are unique circumstances that prevent the DHS **from** allowing voluntary enrollment in the COHS counties at the present time.

For coordination of health services to foster and **AAP** children who are enrolled in a COHS health plan while involved in an out-of-county placement, the following information may be used to expedite the coordination process:

Orange County **(CalOPTIMA)** - Membership Services, Ms. Clara Seal, (714) 246-8753.

San Mateo County (Health Plan of San Mateo) - Membership Services, (800) 750-4776 or (415) 573-9605.

Santa Barbara County (Santa Barbara, Health Initiative) - Ms. Elizabeth Long, Director of Membership Services (800) 421-2560 or (805) 963-9261.

Santa Cruz County (Santa **Cruz** County Health Options) - Membership Services, Grievance Coordinator - Ms. Danita **Carlson** (800) 700-3874 or (408) 457-3850.

Solano County (Solano Partnership Health Plan) - Membership Services Representatives, (800) 863-4155 or (707) 863-4120.

In the event an inquiry is made from out-of-county social services personnel, it will always be good policy to determine the eligibility status of the foster or AAP child before making the telephone call to the health plan because in some cases the eligibility information has not reached all concerned parties.

BACKGROUND

The Medi-Cal program is currently developing Medi-Cal "Two-Plan Model" managed care programs in all of the counties listed above except Sacramento and San Diego. Under the Two-Plan Model program, most Aid to Families with Dependent Children (AFDC)-linked Medi-Cal beneficiaries will be required to enroll in a comprehensive managed care plan to receive Medi-Cal benefits.

Except in Fresno County, beneficiaries will have a choice between a "Commercial" managed care plan that has been awarded a contract through a request for proposals process, or a "Local Initiative" managed care plan that has been developed through a partnership typically involving the county's health agency and hospitals, traditional Medi-Cal fee-for-service and managed care providers, and nonprofit hospitals, clinics, and other health care providers associated with the health care "safety net" for the medically indigent.

No Local Initiative plan was developed in Fresno County; therefore, most AFDC-linked Medi-Cal beneficiaries will be required to choose between two commercial managed care plans. In Sacramento County, AFDC-linked beneficiaries are required to select from a number of commercial managed care plans. Similarly, in San Diego County, most AFDC-linked beneficiaries will be required to select from several commercial managed care plans.

In each of the designated counties, a "health care options" (HCO) entity contracting with the DHS will furnish information about managed care plan choices and enrollment requirements, enrollment exceptions, enrollment, plan transfer, disenrollment processes, and time frames to the AFDC-linked Medi-Cal beneficiaries who are required to select a managed care plan. The HCO contractor has multi-lingual staff to process all enrollment, disenrollment, and plan transfer transactions, to explain the managed care program, to answer beneficiary questions, and to handle membership problems for all beneficiaries required to participate in the managed care program. County welfare department staff should refer all questions or complaints from beneficiaries relating to managed care plan enrollment, disenrollment, or services to the HCO contractor. The current HCO contractor, Benova, Inc., will be replaced with a new HCO contractor, Maximus,

effective January 1, 1997. The DHS is working to minimize disruption upon takeover of the HCO contract by Maximus. HCO enrollment/disenrollment forms, processing, locations, and phone numbers should mostly remain unchanged.

The Sacramento County GMC program has been operational since April 1994. The Two-Plan Model program, with both the commercial plan and local initiative plan operational, began in Alameda County in July 1996 and in Kern County in September 1996. The DHS expects to phase-in the referenced Medi-Cal managed care programs in the other counties specified above over the next six months. Current AFDC-linked Medi-Cal beneficiaries will receive notification of all program requirements sufficiently in advance of the start-up date of the two-plan program in each county, to allow a reasonable time to consult with the HCO contractor and to make a plan selection. Newly eligible AFDC-linked Medi-Cal beneficiaries will be referred to the HCO process by county welfare department workers. In either case, beneficiaries will be given a fixed time period to select a managed care plan. Beneficiaries who do not select a plan in the time allotted will be enrolled in a plan by the HCO contractor. Beneficiaries will be allowed to change plans at any time. A change of plans will generally take from 15 to 45 days, depending on whether or not the request coincides with the monthly Medi-Cal Eligibility Data System (MEDS) processing schedule.

POLICY ON ENROLLMENT OF FOSTER CHILDREN AND CHILDREN RECEIVING ADOPTIONS ASSISTANCE

Children with Medi-Cal eligibility who are under the supervision of county foster care agencies and children receiving Medi-Cal coverage through the Adoptions Assistance Program (AAP) will not be required to enroll in a Medi-Cal managed care plan and shall not be included in the mandatory enrollment category. Bnrollment will be voluntary.

The decision to enroll a child who is under the supervision of a county foster care agency will be left to the discretion of the responsible county director of social services or his/her designee, or the person who has legal authority to make such health care decisions for a foster child. During the 1996-97 fiscal year, voluntary enrollment of a foster child requires a determination on a case-by-case basis by the county director of social services or his/her designee, with the concurrence of the child's caretaker, that enrollment is in the child's best interest. The decision to enroll a child who is receiving Medi-Cal coverage through AAP will be made by the person who has legal authority to make such health care decisions for the child. Usually this will be the adoptive parents.

No action is required by a county foster care or adoptions agency to exclude all foster care or AAP children from the Two-Plan or GMC managed care programs in the designated counties. The following Medi-Cal aid codes will be systematically excluded by DHS from the mandatory managed care plan enrollment process in the 14 counties identified in this letter:

40 - State Foster Care
42 - Federal Foster Care
4C - Federal Voluntary Foster Care
SK - Emergency Assistance Program - Child Welfare Cases in Foster Care
03 - Federal AAP
04 - State AAP

*Counties should note the "4K - Emergency Assistance (EA) program - Juvenile Probation Cases in Foster Care" Medi-Cal aid code has not been included in the above list of aid codes, and should no longer be used for probation foster care children. Federal EA fimding for children under the "4K" aid code has been terminated and counties have been instructed by the California Department of Social Services to stop using the "4K" aid code. The "4K" aid code has not yet been deleted from MEDS.

CHILDREN WHO CANNOT BE IDENTIFIED AS FOSTER CARE BY MEDI-CAL AID CODE

Medi-Cal eligible children in foster care and under the supervision of a local foster care agency may be covered under many standard or special Medi-Cal aid code categories that do not allow for a child to immediately be identified as foster care. These include, but are not limited to, Aid Codes 01, 30, 32, 45, and 60. Among these are foster children in relative placement, who have aid codes that are AFDC in a Family Group, and not AFDC in Foster Care. Thus, foster children, or the person responsible for a foster child, may receive notification of the requirement that a Medi-Cal managed care plan be selected for the child. It is also possible that a foster child will be inadvertently enrolled in a health plan through the HCO assignment process. In these cases, the caseworker will have the option to disenroll the child, based on a determination of the child's best interest and the desires of the caretaker. Caretakers and other responsible parties should be notified of this option by the local foster care agency. If the caseworker or other responsible party determines that disenrollment from the managed care plan is best for the child, he or she must arrange for disenrollment by contacting the HCO contractor and completing a disenrollment form. The HCO contractor has been instructed to disenroll foster care or AAP

children on an expedited (within 48 hours) basis when requested by the child's caseworker, county designated responsible party, or the adoptive family. The HCO contractor can be contacted toll-free at (800) 430-4263.

ENROLLMENT OF FOSTER CARE AND AAP CHILDREN IN A MEDI-CAL MANAGED CARE PLAN

Medi-Cal managed care plan enrollment forms are available from the HCO contractor. A county director of social services or his/her designee in one of the designated counties, or the Probation Officer in the case of a foster child who is a ward of the court, deciding to enroll a foster child voluntarily into an available managed care plan may do so by submitting completed enrollment form to the HCO contractor. Similarly, an adoptive parent may voluntarily enroll an AAP child into an available managed care plan by submitting a completed enrollment form to the HCO contractor.

RECIPROCITY

According to April 1996 data provided by the California Department of Social Services, approximately 14 percent of all foster care cases are placed in a county other than the county in which the agency responsible for, the supervision of the child is located.

Foster care children placed out-of-county universally retain the Medi-Cal code of the county in which the child's placement originated. To date, the Medi-Cal program does not currently have the capacity to establish reciprocity arrangements that would allow for a foster care child placed out-of-county who retains the Medi-Cal code of the county which retains legal jurisdiction to receive health care services from a Medi-Cal managed care plan operating in the county in which the child is subsequently placed. Therefore, it is recommended that foster children placed out-of-county should not be enrolled in a Medi-Cal managed care plan in their county of jurisdiction until appropriate reciprocity arrangements between providers are made, e.g., the child's Medi-Cal fee-for-service providers in the county of placement are willing to provide care and bill the managed care plan.

The DHS would like to receive input from county foster care and adoptions agency directors regarding reciprocity policies and processes might best be established to serve the needs of Medi-Cal eligible foster care and AAP children through Medi-Cal managed care plans. Please provide written suggestions to:

Joseph A. Kelly, Chief
Medi-Cal Managed Care Division
California Department of Health Services
714 P Street, Room 650
Sacramento, CA 958 14

QUESTIONS

If you have questions about this letter, please contact Mr. Alan Stohnack, Chief of the Policy Support and Development Section, Medi-Cal Managed Care Division, Department of Health Services, at (916) 653-5277.

Sincerely,

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

MEDI-CAL

What It Means To You

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES

English/Spanish
Inglés/Español

TABLE OF CONTENTS

1. *MEDI-CAL - WHAT IT MEANS TO YOU*

MEDI-CAL pays for health care for certain needy residents of California. MEDI-CAL is supported by federal and state taxes. This pamphlet tells about who can get MEDI-CAL, the services available to those determined eligible for full or restricted benefits, the choices for getting services, how to use the permanent plastic California Benefits Identification Card (BIC), or the paper MEDICAL card, and your appeal rights if you feel you are treated unfairly or do not get what you are entitled to get by law.

You can get MEDI-CAL benefits regardless of sex, race, religion, color, national origin, sexual orientation, marital status, age, disability, or veteran status.

Your local County Welfare Department (CWD) manages MEDI-CAL eligibility determinations. If you have questions, you can find the addresses and telephone numbers of the welfare departments in the back of this pamphlet.

If you do not know some of the MEDI-CAL terms or words, you can turn to the back pages of this pamphlet for the meanings of those words.

A Spanish translation of the pamphlet follows the English.

2. *WHO CAN GET MEDI-CAL?*

Even if you are working, own a house, or are married, you may be eligible for MEDI-CAL. To get MEDI-CAL, you must fall into one of the following MEDI-CAL program categories:

A. PUBLIC ASSISTANCE (PA): If you are aged (65 years old or older), blind, or disabled and you are getting Supplemental Security Income/State Supplementary Program (SSI/SSP), you are automatically eligible for MEDI-CAL and will be sent a California Benefits Identification Card (BIC). Your Social Security district office can give you more information.

If you are getting Aid to Families with Dependent Children (AFDC), you may also be entitled to get MEDI-CAL benefits. If you are getting other kinds of Public Assistance, you may be entitled to all the services covered by MEDI-CAL. Your county eligibility worker can give you more information.

If you are not in one of these assistance groups, you still may be able to get MEDICAL benefits in one of two categories called Medically Needy (MN) or Medically Indigent (MI). MN and MI programs are for people who cannot pay all their medical expenses. Even if you have other private health insurance coverage, you may still be MN or MI.

B. MEDICALLY NEEDY (MN): You are Medically Needy if you are age 65 or older, blind, disabled, or you meet the family circumstances required for AFDC (you have minor children who are needy and do not have the support or care of one parent because of his/her absence, death, incapacity, or unemployment). MN people do not get a cash grant because they have too much income or property or do not want a

ı grant. You may become eligible for MEDICAL and get a California Benefits ıtification Card (BIC) by paying or promising to pay medical expenses which equal r "share of cost" (SOC) for the month. (See Sections 10 and 11 in this pamphlet.)

ıEDICALLY INDIGENT (MI): You are Medically Indigent if you are a pregnant nan with no linkage (connection) to a PA program (AFDC); a refugee in the ntry 12 months or less; or a person age 21 to 65 in a skilled nursing facility or rmediate care facility. Persons under 21 years of age, including those in foster care ɔse needs are met by public funds, children who qualify for the State-only Aid for ɔption of Children and certain other children not living with a parent or relative also be included in the MI group.

PECIAL PROGRAMS:

'RECNANT WOMEN

you are pregnant and cannot afford to pay for health care, MEDICAL can ıelp pay for medical expenses for you and your baby. Many times you can get AEDI-CAL at no cost to you, even if you have income. Once you get MEDI-CAL, ıcreases in your family's income will not be counted:

during your pregnancy, and
for your baby's first year of life.

articipating perinatal providers throughout California can offer the pregnant ɔatient immediate, temporary MEDI-CAL coverage pending the formal MEDICAL pplication under a new program called Presumptive Eligibility for pregnant vomen. If you are pregnant and interested in this service, ask if your provider ɔarticipates in this program.

:HILDREN

ɔur child may get MEDI-CAL at no cost, if your child is:

an infant, or
between ages 1 and 6, or
between ages 6 and 18, AND born after September 30, 1983.

:FUGEES

you are a refugee or entrant not qualified for the MN or MI programs, ask your ɔunty eligibility worker for refugee/entrant medical assistance.

ONFIDENTIAL MEDICAL SERVICES AVAILABLE TO PERSONS UNDER ACE 21

you are under 21 years of age, unmarried, and living with your parents, you may et certain confidential medical services regardless of citizenship or immigration tatus. Under the Minor Consent program, you do not need parental consent to et a MEDI-CAL card. Only your own income and property will be counted to etermine eligibility. Medical services included under this special program are lose which relate to family planning, pregnancy, drug/alcohol abuse, VD and ther sexually transmitted diseases, sexual assault, and mental health (which ıcludes child or sexual abuse).

- ***ADDITIONAL SERVICES AVAILABLE TO PERSONS UNDER ACE 21 THROUGH THE EARL' AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM***
  If you or your child are under age 21, you may be able to get more or different services through MEDI-CAL than persons age 21 or over if the services are medicall necessary. This is so that children and young adults under 21 years of age can get all the health care services they need to make sure health problems are found and treated early. (See Section 19 on Page 14 for more details.)

- ***MEDICAL SUPPORT ENFORCEMENT***
  All children have the right to be supported by both parents. If you are applying for MEDI-CAL benefits, you must cooperate in establishing paternity for a child(ren) born out of wedlock and obtaining medical support for a child(ren) who has an absent parent. You will be provided all child support services unless you notify the FSD/DA that you do not want to receive those services that are unrelated to obtaining medical support and establishing paternity. Some of the available services are as follows:
  - Locating the parent(s) for support enforcement purposes;
  - Establishing paternity;
  - Establishing a child and/or medical support (health insurance) order;
  - Enforcing a child and/or medical support order;
  - Modifying an existing court order for child and/or medical support;
  - Enforcing a spousal support order in conjunction with a child support order;
  - Collecting and distributing support payments.

  CUSTODY AND VISITATION SERVICES ARE NOT PROVIDED

- ***OTHER***
  You might qualify for medical assistance in one of the miscellaneous categories. Ask your county eligibility worker to help you.

E. SPECIAL TREATMENT PROGRAMS: If you need dialysis treatment or parenteral hyperalimentation services, you may be eligible for services under these programs.

F. SPECIAL MEDICARE PAYMENT PROGRAMS: Some MEDICAL programs such as th ***BUY-IN Program*** and the ***Qualified Medicare Beneficiary (QMB) Program*** will pay for Medicare premiums, and you will not be billed for your co-insurance and deductible The ***Qualified Disabled Working Individual (QDWI)*** *Program* pays the Medicare Part A premium and the ***Specified Low-Income Beneficiary (SLMB) Program*** pays the Medicare Part B premium.

C. AMNESTY ALIENS: Congress passed a law in 1986 which granted amnesty to alien who previously did not have the right to remain in the U.S. If you are an amnesty alie and also blind, disabled, under age 18, or age 65 or older, you may get full MEDI-CA benefits. If you are not blind, disabled, under age 18, or age 65 or older, you may onl get restricted MEDI-CAL benefits during the first five years of your legalization, if otherwise eligible.

WHAT DOES IT MEAN TO BE "DISABLED" FOR MEDI-CAL?

get MEDI-CAL as a disabled person, you must have severe physical and/or mental blem(s) which will:

- last at least 12 months in a row and,
- stop you from working during those 12 months, OR
- possibly result in death.

must prove your disabling physical and/or mental problem(s) with medical ords, tests, and other medical findings. The medical problem must be the main son why you do not work.

get MEDI-CAL for a disabled child, the child must have severe physical and/or ntal problem(s) which:

- are on a list of disabling childhood conditions OR
- are so severe that he/she would not be able to do daily activities which a healthy child would be able to do.

ou have a severe physical and/or mental problem that is on a list of disabling ıditions, you may be able to get MEDICAL based on disability prior to the final .ermination of disability. (This also applies to children.) Ask your eligibility worker more information about Presumptive Disability.

HOW MUCH MONEY CAN I GET AND STILL GET MEDI-CAL?

ı can get MEDI-CAL regardless of how much money you get. However, the more money ı get, the more you will have to pay or promise to pay toward your medical bills before .DI-CAL will help pay your other medical bills. (See Sections 10 and 11 in this pamphlet.)

WHAT PROPERTY/ASSETS ARE ALLOWABLE FOR MEDI-CAL?

ere are property/asset limits for the MEDI-CAL program. If your property/assets are over MEDI-CAL property limit, you will not get MEDI-CAL unless you lower them according program rules. The county looks at how much you and your family have each month. 'our property/assets are below the limit at any time during that month, you will get EDI-CAL, if otherwise eligible. If you have more than the limit for a whole month, you l be discontinued. The home you live in, furnishings, personal items, and one motor ıicle are not counted. A single person is allowed to keep 62000 in property/assets, ore if you are married and/or have a family. If a child has property/assets or if a pparent wants MEDI-CAL for a stepchild, other rules may apply.

PORTANT: If you or your spouse (husband or wife) went into a medical institution or rsing facility on or after September 30, 1989, and were expected to remain for 30 ys while the spouse was still at home, and if applying in 1994, the spouse at home ay keep up to $72,660 in some cases. (This amount generally changes every year.)

r more information on MEDI-CAL property/asset rules, please ask your county lfare department for a form called "MEDI-CAL General Property Limitations for all DI-CAL Applicants" (MC Information Notice 007) If you or your spouse were in a nursing facility before September 30, 1989, also ask for a form called "Community Property – Person in Long-Term Care (LTC)" (MC Information Notice 005).

6. MUST I LIVE IN CALIFORNIA TO GET MEDI-CAL?

Yes. You must be a resident of California in order to get MEDI-CAL.

You must also give evidence that you are a resident of California before your MEDI-CAL can be approved. You must give one of the following listed items to the eligibility worker:

1. A recent California rent or mortgage receipt or utility bill in your name, or
2. A current and valid California motor vehicle driver's license or Identification Ca issued by the California Department of Motor Vehicles in your name, or
3. A current and valid California motor vehicle registration in your name, or
4. A document showing you are employed in California, or
5. A document showing you are registered with a public or private employment service in California, or
6. Evidence that you or your children are enrolled in school in California, or
7. Evidence that you are receiving public assistance, other than MEDI-CAL, in California, or
8. Evidence that you are registered to vote in California, or
9. Other acceptable evidence of your California residence, if you declare, under penalty of perjury, that you do not have any of the documents or evidence list in Sections 1 through 8.

However, you do not have to give this evidence if:

1. You are applying for Minor Consent services, or
2. You are the child of a parent who has also applied for MEDI-CAL and given evidence of California residence, or
3. Your wife or husband has applied for MEDI-CAL and given evidence of Californ residence, if she or he lives at your same address.

7. WHERE DO I APPLY FOR MEDI-CAL?

You should apply for MEDI-CAL at your local County Welfare Department office near you. You can find the addresses and phone numbers of the welfare departments in tl back of this pamphlet. MEDI-CAL eligibility workers may be located at some health clinics or hospitals where you get health care services. Ask your local county welfare department to tell you where you can apply in your area.

If you get an SSI/SSP grant, MEDI-CAL eligibility is automatically set up by your Soci Security district office.

8. HOW DO I APPLY FOR MEDI-CAL?

If you are pregnant or in immediate need of medical care, ask the eligibility worker w interviews you for "expedited service." The county welfare department will process y

lication as fast as possible. Pregnancy is considered an immediate medical need. Be to tell your eligibility worker right away when you apply if you have a medical ointment soon.

se read the pamphlet section called "What Do I Need to Bring for Verification?" so you know what to bring to the office when you apply for MEDICAL. You can ed up the process by bringing in the necessary information and paperwork quickly. usual application procedure is:

Get a MEDI-CAL application from the county welfare department in your area.

ill out the form(s) as completely as you can.

'ou should apply for MEDI-CAL "retroactive benefits" if you had medical services in the e months before the month you apply for MEDI-CAL, and you think you will need) from MEDI-CAL to pay the bills. If you were eligible for MEDICAL during the three nths before the month you apply, even if you have paid the bills, MEDI-CAL may pay se bills. You can apply for "retroactive" MEDICAL at the same time you apply for DI-CAL. If you don't ask for retroactive MEDICAL until after you start getting DI-CAL, you have up to one year to ask for MEDICAL for that retroactive month.

When you apply for MEDI-CAL, your eligibility worker will explain your rights and ponsibilities. You must give any changes in address, property, income, family nposition, other circumstances, and private health insurance coverage to your ibility worker within ten days.

Return the application form and wait to be seen by or given an appointment with eligibility worker. You will receive additional forms to fill out. Bring all the necessary perwork, including proof of all information, with YOU to the interview.

TE: In some counties, when you are a MEDI-CAL "beneficiary" (that's what you are ed when you get MEDI-CAL) you may be required to sign up for a MEDI-CAL medical n and/or dental plan, If you are required to sign up for a medical or dental plan, you y choose a personal doctor and/or dentist from a list given to you by the medical and ntal plans.

ou live in one of those counties where there are MEDI-CAL medical and dental plans, J will receive additional information about the choices you have available for getting ur MEDI-CAL benefits and the plans offered to you. You will receive this information the time you apply for benefits, or when the county redetermines your benefits. In ne cases, you will receive information about the medical and dental plans available, d information about how to enroll in the plans, through the mail.

It may take up to 45 days for your MEDI-CAL application to be processed. If you are plying for MEDI-CAL based on disability, your application process may take 90 days. 'ou think you have an immediate medical need, tell your eligibility worker and your plication may be processed faster. You can speed up the process by bringing in the ecessary information and paperwork quickly.

7. You will get a letter in the mail telling you if your MEDI-CAL application is approved or denied. If you choose to sign up for a MEDICAL health care plan, you will get a health ca plan identification card in addition to the State-issued BIC.

8. If YOU do not get an answer to your MEDI-CAL application within a month after yc apply, call your eligibility worker.

9. WHAT DO I NEED TO BRING FOR VERIFICATION (PROOF)?

You must give certain information before your MEDI-CAL can be approved. Your eligibility worker will tell you what this proof is.

You may apply without the proof, but you will have to give it within a few days. If yc cannot get the proof yourself, ask your eligibility worker to help you.

ITEMS REQUIRED for full MEDI-CAL benefits (if applicable):

1. Social Security card(s).
2. Medicare card(s).
3. Naturalization document(s).
4. Alien registration card(s).
5. Pregnancy verification.
6. Income verification:
   a. Employee pay stubs or a statement from your employer showing gross earnings and deductions.
   b. Award letter or checks showing amount of pension or benefits, including Social Security and V.A.
   c. State Unemployment or Disability award letter.
   d. Student Loan grant award letter(s) or loan grant papers.
   e. Statement from providers of other income (contributions, refunds, child support, etc.).
   f. Self-employment information: Last year's tax return or current ledgers, current inventory, including business equipment and supplies.
   g. Care costs for child/incapacitated person(s).
7. Property Tax statements for all property.
8. Vehicle Registration(s) for automobiles, boats, campers and trailers.
9. All checking and savings account statements and trust account documents.
10. All stocks (brokerage statements), bonds (including U.S. Savings bonds) and mutual funds.
11. All deeds of trust, mortgages, other promissory notes and contracts of sale.
12. All life insurance policies, including cash surrender value.
13. Ail annuity policies.
14. All burial trusts/prepaid burial contracts/information on burial plots.
15. Documentation regarding the current value of all trusts.
16. Payment book(s) for all encumbered property.
17. All policies/cards for health insurance you currently have or which are available to yc
18. Application(s) for possible available income (i.e. unemployment benefits, state disability benefits)

Court orders relating to income and property.
Lease agreements.
Life estate documents.
Copies of patient trust account ledgers.
Rent receipts, current utility bills, or housing statement.
Copies of child support orders or divorce decree.
Social Security disability or SSI denial or discontinuance notice (if applying for disability-based MEDI-CAL).
Evidence of California residency.

WILL I HAVE A SHARE Of COST AND HOW MUCH WILL IT BE?

ending upon your monthly income, MEDI-CAL may determine that you have to t a share of cost (SOC) before MEDI-CAL will pay for your, or your family's, ical expenses for the month. The next section explains "meeting a share of cost."

ther you will have a SOC for a month, and the size of your SOC, depends on much money or income you and your family get for the month,. MEDICAL vs you to keep a certain amount of your family's income for your living expenses portion is called your Maintenance Need). MEDI-CAL may also allow you to keep tional amounts of your family's income. Any income for the month which is more the amount you are allowed to keep becomes your SOC for the month.

me families, the income of one person cannot be used to decide if another on has a SOC. For example, income of a child cannot be used to decide whether other or sister, parent, stepparent or caretaker relative has a SOC. Income of a parent cannot be used to see if a stepchild has a SOC.

u don't have any medical expenses during a month, you do not need to show that met your SOC for that month. However, keep your BIC in case you need medical ices in upcoming months.

HOW DO I MEET MY SHARE OF COST?

may meet your SOC for the current month by showing MEDI-CAL that you have l, or have promised to pay, for your medical expenses an amount of money the e as your SOC. There are two ways to show MEDI-CAL that you have paid or nised to pay your SOC for a certain month. These two methods are:

every month that you have a SOC, your county will notify the State of the amount of you must pay. When you go to a medical provider and give the provider your BIC, your ider will be able to obtain information from a computer system about your SOC. After provider accepts your promise to pay for the medical services, or you pay for those ces, the provider will forward the amount of SOC paid, or promised to be paid, through computer system to the State. The State will immediately update the SOC system so that e providers will know the amount of SOC that remains, if any. When you have met your for the month, all future providers will receive information that you have met your SOC ne month and whether or not you are eligible for covered MEDI-CAL services.

2. Another way to show you have paid or promised to pay your SOC is to take your medical bills directly to your county eligibility worker. You may take your bills for medk services you got during the current month to your county eligibility worker to apply toward your SOC. You must take old medical bills from previous months (for which you still owe money and which you want to apply toward your SOC) to your eligibility worker. Your provider cannot use the SOC computer system for your old medical bills.

Medical bills brought to your eligibility worker must contain certain kinds of information before your eligibility worker can apply these bills toward your SOC. Your medical bills must show this information:

1. Provider's name and address.
2. Name of person who got the medical service.
3. Description of the medical service received.
4. Procedure Code (a medical/dental reference number) for medical/dental services received -your provider will know what this number is.
5. Provider's MEDI-CAL provider number, or if not a MEDI-CAL provider, the provider license number, or federal tax identification number.
6. Date(s) medical service was received.
7. Date on which bill was issued. For old medical bills, this date must be within 90 days of the date you give the old medical bills to your county worker.
8. Amount billed to person getting the service.

If any of this information is missing from a medical bill, you must try to get it from your provider. If you are unable to get it, your eligibility worker will try to help you. Billing statements from collection agencies and credit card statements sometimes may be used as evidence of medical expenses. Under certain conditions, you may give the missing information by making a sworn statement.

If your eligibility worker is unable to accept a medical bill, you will get a letter giving the reason for the disapproval of the bill. You will have ten days to fix the problem an bring/send the bill again. If you do not do this, you will receive a denial letter within the next 30 days which will give the reason for the denial and tell you what you must do before you may bring/send your medical bill again. You will get a separate letter f medical bills which have been accepted and applied toward your SOC.

*72. WHAT IF I HAVE PRIVATE HEALTH **INSURANCE** COVERAGE?*

You can have MEDI-CAL even though you have private health coverage. If you are a MEDI-CAL beneficiary and have individual or group private health insurance coverage, you are required by federal and state law to report it. This information must be given to your county welfare department, to your health care provider, and/or to the Family Support Division/District Attorney (FSD/DA), when there is an absent parent who may be responsible for your child(ren)'s medical care, or in a paternity establishment when a child is born out of wedlock. If you fail to report any private health insurance coverage that you have, you are committing a misdemeanc

Under Federal law, health insurance belonging to a **MEDI-CAL** recipient in a child or medical support enforcement case is used as follows:

provider of service will bill MEDI-CAL MEDI-CAL will pay the provider of service. Then DI-CAL will seek repayment from the other health coverage. You will not be liable for insurance cost-sharing amount (coinsurance or deductible) unless a MEDI-CAL share of t must be met If your other health insurance is a Prepaid Health Plan (PHP) or a Health ntenance Organization (HMO), you must use the plan facilities for regular medical care. : of area services or emergency care should also be billed to the PHP/HMO.

:refore, you must tell your eligibility worker (EW) and/or the FSD/DA:

- if you, your child(ren), or the other parent of your child(ren) has private health insurance coverage.
- when the private health insurance coverage is through your employer, your union, or a group or organization.
- within ten days, when your private health insurance coverage changes or stops.
- about any court order (such as divorce judgment or temporary support order) which makes the other parent responsible for providing health insurance.

1 must:

- give your medical provider any information needed to bill your private health insurance coverage.
- send to the Department of Health Services' Third Party Liability Branch any payment you get directly from an insurance carrier for services paid by MEDI-CAL. The address is:

Department of Health Services
Third Party Liability Branch
Health Insurance Section
P.O. Box 671
Sacramento, CA 95812-6710

1 must:

- send to the Department of,Health Services' Third Party Liability Branch any medical support payment you get from the absent parent. The address is:

Department of Health Services
Third Party Liability Branch
Recovery Section
P.O. Box 2946
Sacramento, CA 95812-2946

- use your health maintenance organization (HMO), and/or prepaid health plan (PHP), such as Kaiser Health Plan, CHAMPUS, or military coverage, for. regular medical care. Out of area services for emergency care should also be billed to the HMO/PHP.
- use your BIC only for MEDI-CAL covered services that your prepaid or health maintenance plan or military insurance does not cover.

'ou have other health insurance coverage, the computer system will be coded to)w other health insurance.

)rovider (doctor or pharmacy) may not refuse to provide service or fill your prescription ely because you have other health insurance coverage (in addition to MEDI-CAL). If you not have other health insurance coverage and the computer system is coded that you do, ask your eligibility worker to correct the coding on the computer system. If you have SSI and the computer system is incorrectly coded to show other health insurance coverage, a you do not have it, please call the Department of Health Services' Health Insurance Sectio at I-800-952-5294 (toll-free) to correct the coding on the computer system.

If you are having a claims payment problem with a provider, you may call the Electronic Data Systems Beneficiary Inquiry Unit at (916) 636-I 980.

73. WILL MEDI-CAL PAY MY PRIVATE HEALTH INSURANCE PREMIUMS IF I CAN NO LONGER AFFORD TO MAKE PAYMENT

If you are a MEDI-CAL beneficiary and you have a very high-cost medical condition which requires a physician's care, the Department of Health Services may pay your private health insurance premiums, if it is cost effective, under the Health Insurance Premium Payment (HIPP) program. There are specific requirements to qualify for the program and not all applicants are approved for HIPP. For more information on HIPP

- ask your eligibility worker to refer you, or
- call the Department of Health Services' HIPP Program at I-800-952-5294 (toll-fr

A HIPP representative in Sacramento will explain the process and requirements for t program. If it appears that you may meet the eligibility requirements, an applicatio will be sent to you.

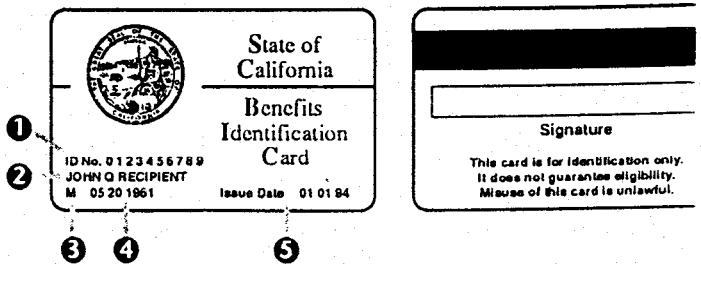
74. IS THERE A NEW MEDI-CAL CARD FOR 1994?

Starting in early 1994, and over a period of months, a new permanent plastic California Benefits Identification Card (BIC) will be sent to MEDICAL beneficiaries throughout Califor on a county by county basis. In this pamphlet, the new MEDI-CAL card will be called BIC The "old" MEDI-CAL card will be called the paper MEDI-CAL card. When you get a BIC do not hrow it away. You will not get a new plastic ID card (BIC) every mon

NOTE: THE BENEFITS IDENTIFICATION CARD (SIC) DOES NOT GUARANTEE MEDI-CAL ELIGIBILITY. Take this card to your doctor, pharmacy, hospital or other medical provider. The provider will use this card to obtain information to determine if you are eligible for MEDI-CAL.

75. WHAT DOES THE BENEFITS IDENTIFICATION CARD (BIC) LOOK LIK

A BIC looks like this:



Recipient information on face of card:

1. Your ID Number (your Social Security Number or Client Index Number (CIN) ending
2. Your name
4. Date of Birth

5. WILL I STILL GET A PAPER MEDI-CAL CARD?

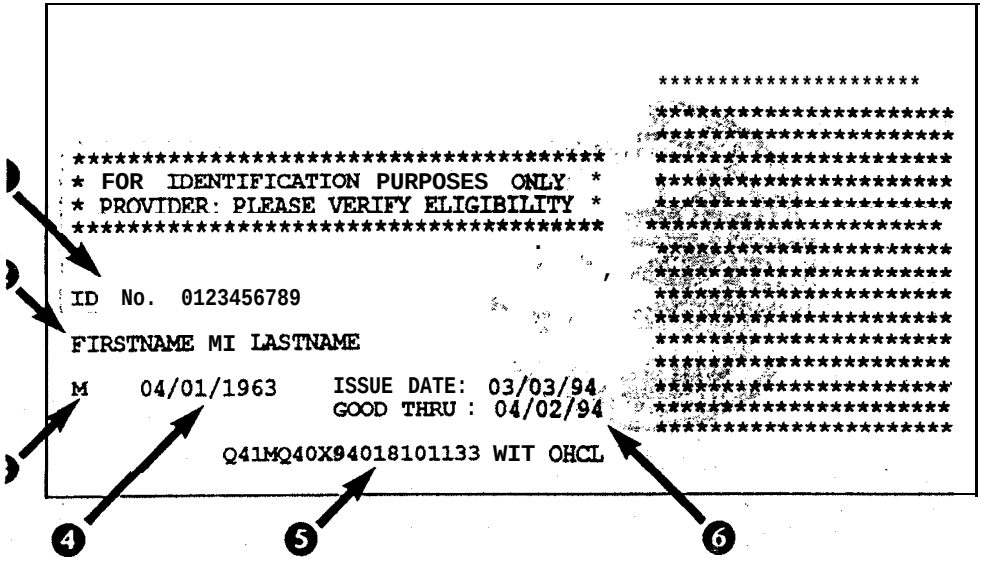
:er beneficiaries in all the counties get the BIC, only MEDI-CAL beneficiaries who get ɔnfidential Medical Services (as described on page 2) and those beneficiaries in nmediate need" will get a paper MEDICAL card.

7. WHAT DOES THE INFORMATION ON THE PAPER MEDI-CAL CARD MEAN?

ıe new paper MEDI-CAL card looks like this:

New Paper ID Card for immediate Need and Minor Consent Recipients

(Actual card size = 6½" x 3½", background print isgreen.)



MEDI-CAL ID Number
Recipient Name
Gender
Date of Birth
Control Number (For State-use Only)
Issue Date / Good Thru Date

The example dates are for an immediate **Need** recipient.

The dates for a **Minor Consent** recipient would be 03/01/94 to 03/01/95.

OTE: If you are a beneficiary 18 years of age or older who is not in long-term care, ıd not getting emergency services, you must sign and date your paper MEDI-CAL ırd or BIC when you get it and before you give the paper MEDICAL card or BIC to a ·ovider for any care.

18. HOW DO I USE THE BENEFITS IDENTIFICATION CARD (BIC)?

You should always carry your BIC with you.

REMEMBER: Find out if the orovider takes MEDICAL patients before you ao for treatment. The orovider has a riaht to refuse to take MEDI-CAL. If yo'ı foraol to tell the provider that YOU have MEDI-CAL YOU mav have to pav your

Ask your local medical society for providers who take MEDI-CAL **patient** Call the Delta Dental office for dental referrals at (800) 322-6384.

For each service you get, give the provider your BIC so MEDI-CAL can pay the provi (if you are eligible for MEDI-CAL)

Some services must be approved by MEDI-CAL before you may get them. The pro\ will know when you need prior approval.

MEDI SERVICES:

MEDI labels will be phased out as BICs are distributed. Some services are restricted t(two per month. There are a few exceptions, but generally you can only get a total two of the following services:

- Acupuncture services
- Audiology services
- Chiropractic servicer
- Occupational Therapy
- Podiatry services (some)
- Psychology services
- Speech Therapy

If you need any of the above services, discuss your treatment plan and appointmer with your doctor. Your doctor must 'reserve' MEDI services in advance. A reservatic can be cancelled by your doctor if you don't need the service after all or if you nee different service instead.

POE SERVICES:

POE labels will be phased out as BICs are distributed.

1. The following services are not automatically limited but your doctor may need to get prior approval from MEDICAL Your doctor will decide which services you need and ask for approval when it is needed. Some of the services which require prior approval

- Hemodialysis services (kidney treatment)
- Medical transportation
- Nursing home care
- Hospice care
- Some dental services
- Artificial limbs, braces, and eyes
- Hearing aids
- Inpatient hospital care (see MEDI-CAL terms)
- Physical therapy
- Crutches, wheelchairs, and other durable medical equipment
- Prescribed drugs not on the MEDI-CAL drug list
- Medical supplies not on the MEDI-CAL medical supplies list
- Home health – Home and Community-based services as a possible alternative hospital or nursing home care

The following services are not automatically limited and do **not need prior approval:**

- Most doctor's services and most clinic visits
- Laboratory, X-ray, and radiation treatment
- Medical screenings for persons under 21 are available to identify medical problems. You are encouraged to take advantage of this service because regular physical check-ups will help keep your children healthy. Ask your eligibility worker about the Child Health and Disability Prevention Program. If you are pregnant, you can get prenatal care guidance to help you get the care you need to have a healthy baby
- Prescribed drugs on the MEDI-CAL drug list if prescribed for the conditions specified on the list
- Medical supplies on the MEDI-CAL medical supplies list if prescribed for the conditions specified on the list
- Eyeglasses and eye appliances
- Blood and blood derivatives

Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) services do not require prior approval. However, these services may be limited.

9. WHAT ADDITIONAL BENEFITS ARE AVAILABLE TO PERSONS UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) PROGRAM?

ıe Federal Government and the State provide funding for services over and above ose listed in Section 18 to persons under 21 if they are medically-necessary to correct ameliorate physical and mental health problems or conditions discovered during a ıit to a licensed health care professional.

ır example, if you or your child needs more than two speech or hearing services ıring the month, your provider can ask MEDI-CAL for authorization to provide them, ıd MEDI-CAL will pay for them if they are determined medically necessary. Also, if ıu need help in finding the services you need, MEDI-CAL may be able to help.

you or your doctor think that health services which are not usually covered by EDI-CAL may be needed, you should talk to:

- Your local county Child Health and Disability Prevention Prog-am
- The Managed Care Plan you're enrolled in

r ask your doctor to contact:

- Your local MEDI-CAL Field Office, or
- The California Children's Services Program

0. WHAT IF I LOSE MY B/C, IT IS STOLEN, OR I DO NOT GET IT WHEN I SHOULD?

ɔu may ask for a BIC from your CWD when you are eligible for MEDI-CAL but you ıve not gotten a card, you lost your card, your card was stolen, or the card you got the mail has wrong information on it.

your BIC is stolen, you must tell your local police and your CWD. You should give as

If you get SSI/SSP or AFDC each month, you should automatically get a BIC in the m If you do not get a card, you should contact your CWD. Even though the county doe not make SSI/SSP eligibility determinations or send SSI/SSP checks, they help with BI problems for people who get SSI/SSP. The county can order a replacement BIC for yo The CWD will tell you if you also need to contact a Social Security office to correct th problem with your BIC.

21. HOW DO I GET SERVICES WITH MEDI-CAL?

There are two ways to get your MEDI-CAL services. How you get your MEDI-CAL services will depend on the area you live in. In some areas, you may choose your providers from those who accept MEDI-CAL, or you may choose to sign up for a MEDI-CAL health care plan'if there are any in your area. In other areas, some MEDI- beneficiaries must sign up for a health care plan. In the areas where you must sign u for a health care plan, there are exceptions. The exceptions will be explained to you the same time your choices for getting MEDI-CAL services are explained to you.

You will get more information about health care plans at the time you apply or rea for benefits. You may be required to go to a presentation at the county welfare department where they tell you about the health care plans you can sign up for. Yo may also get information in the mail about the health care plans in your area.

1. In those areas where you can choose your own providers, you should know how to us BIC before you see a doctor or other provider of health services. Please reaa the sections c "How Do I Use the BIC?" and "What Does the Information on the Paper MEDI-CAL Card Mean?" (Look at the Table of Contents at the front of this pamphlet to find the right pag

If you are not enrolling in a health care plan and choosing your own providers, you must tell the health care provider that you have MEDI-CAL before you first aet care. you do not tell the provider that you have MEDI-CAL, the orovider mav legally bill for all services you aet. Providers of health care do not have to take MEDI-CAL patie or may only take a few MEDI-CAL patients. **If you don't use your BIC correctly, yo may have to pay for the servkes you get.**

2. If you sign up for a MEDI-CAL health care *plan,* you may choose a provider from provider list the plan gives you. As a plan member, you can get all of the services covered by regular MEDI-CAL. Some plans offer extra services which you cannot g with your MEDI-CAL card. In addition, you do not have to pay a "co-payment" wh you are a plan member.

22. WILL MEDI-CAL PAY FOR ALL MY MEDICAL EXPENSES?

Your BIC will pay for many kinds of medical expenses. When your provider uses yo BIC to verify your MEDI-CAL eligibility, your provider will know if MEDI-CAL will pa for a medical treatment or if you need to make a **"co-payment"** for any treatment. may have to pay 41 .OO each time you get a medical service or prescribed drug anc $5.00 if you go to a hospital emergency room when you do not need an emergen service You do nnt have to pay if you are enrolled in a MEDI-CAI health care plan

. HOW CAN I GET HELP FROM MEDI-CAL IF I AM OUT OF STATE.7

e your BIC or proof of enrollment in a MEDI-CAL health care plan with you when
ı travel outside California. MEDI-CAL can help in limited situations; for example, in
emergency due to accident, injury, or severe illness, or when your health would be
langered by postponing treatment until you return to California. MEDI-CAL must
: approve any out-of-state in-patient medical services before you get the service. You
be responsible for medical costs for services you got out-of-state if the medical
vider is not a MEDI-CAL provider or does not wish to become a MEDI-CAL provider.

ɜ provider should first verify eligibility by contacting the fiscal intermediary at
6) 636-l 000. The provider may get information on coverage, authorization
ł billing procedures by contacting the following:

MEDICAL SERVICES	DENTAL SERVICES
Department of Health Services	Delta Dental
MEDI-CAL Field Office	Denti-Cal
P.O. Box 193704	7667 Folsom Blvd.
San Francisco, CA 94119-3704	Sacramento, CA 95826
(4 15) 904-9600	(916) 386-1620, Ext. 3950

ou live near the California state line and use doctors or other providers of medical
vice in the other state, some of these restrictions do not apply.: (However, medical
vices in Mexico or Canada are not covered except for emergency hospitalization.)

u will not get MEDI-CAL if you move out of California. You may apply for Medicaid
the state in which you live.

I. IS MEDI-CAL MANAGED CARE THE SAME AS A HEALTH CARE PLAN?

:. MEDI-CAL Managed Care is a program whereby the State contracts with various medical
›viders to provide services to you in an organized and coordinated manner. The managed
'e plans must directly give, or arrange for, all MEDI-CAL services to you.

5. CAN I GO TO ANY PROVIDER IF I ENROLL IN A HEALTH CARE PLAN?

'ou enroll in a health care plan, you must use the plan providers and clinics unless emergency
'e is needed.

5. HOW DO I JOIN A MANAGED CARE PLAN?

u can ask your eligibility worker if managed care is available and how to contact either the
alth care plan or the local health care options worker.

7. HOW DO I GET OUT OF A MANAGED CARE PLAN?

some areas, if you are in a health care plan, either through voluntary enrollment or through
being assigned to a health plan, you will have to stay in the health plan for a period of six mo
If you join or are assigned to one of these plans, you may diienroll (cancel) for any reason an)
within the first 30 days you are in the plan, or after you have been in the plan six months.

If you are in an area where you have to stay in a health plan for six months before disenrol
you will get more information about this when you sign up for the health care plan.

If you live in an area where the option to join a health care plan is voluntary, you r
disenroll (cancel) at any time. (You contact the plan membership staff at the phon
number provided in the papers you got when you signed up.) It usually takes 45 c
to be cancelled. If membership is mandatory in your area, then you contact the lo
health care options worker for help and to learn all your choices. If you are not
disenrolled in 45 days, contact your eligibility worker for help.

28. WHAT CAN I DO IF I DISAGREE WITH ANY DECISION ABOUT MEDI-CAL ELIGIBILITY OR BENEFITS?

STATE HEARING: You get a Notice of Action (NOA) form in the mail from the CW
whenever your MEDI-CAL eligibility changes. If you disagree with a decision abou
your right to get MEDI-CAL benefits, you should talk to your county eligibility wor
If you are still dissatisfied, you may ask for a State hearing through the CWD or th
State Department of Social. Services. On the back of the NOA, you will find out ho
you can request a State hearing and where to send your request. If you disagree w
the denial of a health benefit, you can also ask for a State hearing. You can also as
a State hearing by writing, calling, or going to:

Public Inquiry and Response Unit
State Department of Social Services
744 P Street, Room 1616
Sacramento, CA 95814

I-800-952-5253 (toll-free)
OR
For the deaf only:
TDD: I-800-952-8349 (toll-free)

You ıust ask for a State hearing within 90 days from the date *on* which you belie
the wrong action took place. If you ask for a hearing before the effective date of tl
action which stopped or lowered your MEDI-CAL benefits, you may continue to g
the same MEDI-CAL benefits until the hearing.

You or your representative can read the regulations about the MEDI-CAL program an
most of the facts in your case. Help is also available in some languages other than En
including Spanish.

At the hearing, an Administrative Law Judge will review the CWD's actions to see
someone made a mistake. You must either go to the hearing or give written notic
someone to go in your place. You may bring others to represent you or as witnes
You may ask questions of the county representative or any County or State witnes

DISCRIMINATION: If you believe a decision about your right to get MEDI-CAL be
was unfairly made because of your sex, race, religion, color, national origin, se
orientation, marital status, age, disability or veterans status, you may file a wril
or telephone complaint with the California State Department of Health Servic

il Rights Office, 714 P Street, Sacramento, CA 95814, (916) 657-I 411. Your nplaint of discrimination will be investigated.

. WHAT IF I HAVE BEEN HURT BY ANOTHER PERSON OR HURT AT WORK?

ou are hurt by another person or hurt at work, you may use your BIC to get ices. You must report the accident or injury to your eligibility worker so that the DI-CAL program can be paid back by the responsible party.

), please be sure to send the following ormation to:

Department of Health Services
P.O. Box 2471
Sacramento, CA 9581 I-9990

Instead of writing, you may call the following offices:
If your last name begins with:
A-F ..... (916) 324-1715
G-P ..... (916) 327-0970
Q-Z ..... (916) 323-0187

Your name, address, and phone number.

Your MEDI-CAL number, and Social Security Number.

The date you were hurt and what happened.

The name, address, and phone number of your attorney, if you hired one,

The name, address, and phone number of the person who hurt you.

The name, address, and phone number of the liable insurance company; also add the policy number.

'f you were hurt at work, the name, address and phone number of your employer.

. WILL MEDI-CAL BILL A DECEASED MEDI-CAL BENEFICIARY'S ESTATE?

DI-CAL **may** claim against the estate of a MEDICAL beneficiary **who has died after** tober 1, 1993, only if:

- MEDI-CAL paid for certain medical services after the beneficiary's 65th birthday, and the deceased MEDICAL beneficiary had no surviving spouse, minor, or totally disabled child(ren), and
- the MEDICAL claim against the estate does not create a substantial hardship on the heirs of the deceased MEDI-CAL beneficiary.

DI-CAL shall impose a lien upon the equity interest in the home or other property of **institutionalized** MEDI-CAL beneficiary if certain conditions are met. Such claims and is may be reduced if it can be demonstrated that a substantial hardship is created on survivors or heirs of the deceased MEDI-CAL beneficiary.

ne surviving spouse of a deceased MEDI-CAL beneficiary dies, MEDI-CAL may bill the estate of the surviving spouse for either the amount paid by MEDI-CAL for medical assistance, or the value of the estate received by the surviving spouse, whichever is les

The estate of individuals of any age may also be billed if that individual had been a resident of a nursing facility.

31. WHAT IS MEDI-CAL FRAUD?

If you are getting treatment from more than one doctor, you should tell each doctc about the other doctor(s) giving care to you. It is your responsibility not to abuse o improperly use your MEDI-CAL benefits. It is a crime to:

- allow others to use your MEDI-CAL benefits, and
- get drugs through false statements.

It is a crime for you to sell or lend your BIC to any person or furnish your BIC to anyone other than your provider of services as required under MEDI-CAL guidelines Misuse of BIC/MEDI-CAL benefits is a crime that could result in administrative actio criminal prosecution. If you suspect someone of misusing MEDI-CAL benefits, you r make a confidential report to one of the following toll-free numbers:

Northern California	Southern California
I-800-822-6223	I-800-822-6222

32. WHAT DO THE WORDS MEAN?

1. BENEFICIARY-A person who has been determined eligible for MEDI-CAL.

2. (MEDI-CAL) HEALTH CARE PLAN -The Department of Health Services contracts with prepaid health plans, health maintenance organizations, and primary care cas management systems to give covered MEDI-CAL services to MEDI-CAL beneficiaries MEDI-CAL beneficiaries who enroll in a plan are guaranteed access to a full range o quality health care, including preventive medical services.

3. HOME AND COMMUNITY-BASED CARE SERVICES - Health care services that ca sometimes be given at home to persons who usually would need to stay in a hospit or nursing home. These services are only available to certain people getting MEDI-C who meet special requirements. Ask your doctor or hospital discharge planner to contact the local MEDI-CAL Field Office if you think you might need these services.

4. INPATIENT HOSPITAL CARE - Care you get when you are admitted to a hospital some areas of the State, you can only get inpatient care at hospitals contracting wit the State. If you need care, you should contact your doctor, and if necessary, your doctor will make arrangements for hospitalization. In a life-threatening emergency, if you are a pregnant woman in active labor, any hospital can give you care.

5. LINKAGE - Persons who meet the federal definition of age (65 years or older), blindness, or disability, or parents and their children who are deprived of parental support or care are considered "linked" (or connected) to one of these categories.

MAINTENANCE NEED – The amount of monthly income MEDI-CAL has determined at a person or family needs for food, clothing, housing, etc. The amount will change th the number of people in the family.

MEDI-CAL – California's name for Medicaid, the federal and state program of edical assistance for needy and low-income persons.

MEDICARE – A federal health insurance program administered by the Social curity Administration which is available regardless of income. Most persons 65 years age or older and certain disabled or blind persons, regardless of age, are covered. edicare Part A covers hospitalization. Medicare Part B covers doctor bills. A Medicare rd is red, white, and blue.

BUY-IN – If you are aged, blind, disabled, getting Title II Social Security payments Railroad Retirement disability benefits, or dialysis-related health care services, you ust apply for Medicare at the Social Security office in order to qualify for MEDI-CAL. you qualify for both Medicare and MEDI-CAL, MEDI-CAL will pay your monthly edicare Part B insurance premiums and MEDICAL may pay your monthly Part A surance premiums. Please tell your doctor you have both Medicare and MEDI-CAL, you will not be billed for the Medicare co-insurance.

OTHER HEALTH CARE COVERAGE -Any private health benefit plan or health surance coverage (whether individual or through a union, group, employer, or ganization) under which payment can be made for health care services provided to ie persons covered by that policy or plan.

3. **PERSONAL PROPERTY** – All liquid and non-liquid assets (other than real property) ich as cash, savings accounts, checking accounts, stocks, bonds, jewelry, boats, life surance policies, recreational vehicles, etc.

1. **PROPERTY RESERVE** – The total net market value of countable property assets of iose persons applying for MEDI-CAL.

2. **REAL PROPERTY** – Land and improvements which generally include any immovable roperty attached to the land and any oil, mineral, timber or other rights related to the land.

3. **SHARE OF COST (SOC)** – The amount you must pay or promise to pay each ionth toward the cost of your health care before MEDI-CAL will pay. Your share of ost may change when your monthly income changes. You only pay a share of cost in month when you get health care services. A SOC is not a monthly charge that you iust pay whether or not you have medical bills.

4. **VERIFICATION** – Acceptable evidence (documents) which gives proof of tatements made by an applicant/beneficiary.

MEDI-CAL

Lo Que Significa **Para Usted**

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES

Inglés/Espai
English/Spani

IMPORTANT INFORMATION FOR NEW SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTARY PAYMENT (SSVSSP) RECIPIENTS

BENEFITS IDENTIFICATION CARD

You are eligible for Medi-Cal benefits because you have been approved for current SSVSSP benefits. You have received or will shortly receive a plastic Benefits Identification Card (BIC). This BIC can be used to verify your eligibility for Medi-Cal benefits, allowing your Medi-Cal providers to bill for medical care. If your doctor or your health provider tells you your Medi-Cal eligibility is for a county in which you do not reside, you must contact your Social Security Administration (SSA) office to have them correct their records.

PAYMENT OF PRIOR MONTH MEDICAL BILLS

The first month of your eligibility for Medi-Cal is the same month as the first month that your SSI/SSP was approved. This may include a number of months before you received your BIC. The following information applies even if the county welfare department previously denied your Medi-Cal disability application because you had been denied SSI/SSP disability benefits. If you had medical services from a Medi-Cal provider, that provider can bill Medi-Cal for those services. However, you must contact the providers you saw during this period so that these providers can bill Medi-Cal.

Payment for services over one (1) year prior to receiving your BIC requires a Letter of Authorization (MC 180). This form is obtained by bringing your award letter or a letter from the Social Security Administration to your local county welfare office. You should bring in copies of your medical bills to assist in determining what month(s) you need to request Medi-Cal benefits. **IMPORTANT. This request should be made within six months of the date of the award letter.**

DO NOT THROW AWAY YOUR BIC. If you got Medi-Cal in the past, you may already have a plastic BIC that can be used again. If you lose your card, contact your local county welfare office and ask for a new card. If you are issued a new card, then your old card must be destroyed.

MEDI-CAL MANAGED CARE

Medi-Cal Managed Care is a State program that contracts with various health care plans. The managed health care plans must provide directly, or arrange, all medical services for you. You can ask your local county welfare office if managed care plans are available. Ask how to contact the health care plan or the local health care options workers.

IF YOUR SSYSSP IS STOPPED

Contact the local county welfare office right away to apply for ongoing Medi-Cal benefits if you receive a notice that your SSYSSP has been stopped.

IF YOU HAVE MORE THAN ONE PROVIDER

If you get treatment from more than one doctor, you should tell each doctor about the other doctor(s). Do not abuse your Medi-Cal benefits. It is a crime to get drugs through false statements or allow others to use your BIC.

IF YOU HAVE PRIVATE HEALTH INSURANCE

As a Medi-Cal beneficiary, you must report any private health insurance you have to the Social Security Administration. **Having private health insurance does not prevent you from being eligible for Medi-Cal; however, if you do not report it, your Medi-Cal benefits can be stopped.** State and federal law requires Medi-Cal providers to bill your private health insurance before billing the Medi-Cal program.

If your private health insurance is through a Prepaid Health Plan or Health Maintenance Organization (PHP/HMO), you must go to your health plan to receive health care services. Medi-Cal may not pay for services available through a PHP/HMO plan if you choose to seek treatment elsewhere.

Additionally, the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) Programs may pay your health insurance premiums for you if it is cost effective. If you have high monthly health care costs and presently have health insurance or have health insurance available to you, you may qualify for one of the two programs.

Questions about Medi-Cal and private health insurance or eligibility requirements for the HIPP/EGHP Programs can be answered between 8:00 a.&. and 5:00 p.m., Monday through Friday, by calling the Department of Health Services' toll-free phone line at l-800-952-5294.

INFORMATION YOU MUST REPORT

You must report any changes in your income, resources, or living arrangements to the Social Security Administration,

You must report when you get Medi-Cal services because of an accident or injury caused by someone else. Report the accident or injury to the Department of Health Services, P.O. Box 2471, Sacramento, California 958 12-2471 or call (916) 323-4836. If you receive any direct payments from insurance for services paid by Medi-Cal, send them to the Department of Health Services, P.O. Box 2946, Sacramento, California 958 12-9973.

MEDICARE

If you do not already get Social Security benefits, you must apply-for Medicare benefits at the local Social Security Administration office if you are 64 years and 9 months of age or older.

STATE OF CALIFORNIA--HEALTH AND WELFARE AGENCY PETE WILSON, Governor
DEPARTMENT OF HEALTH SERVICES
714/744P street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

June 7, 1996

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Letter No 96-26

REDUCTION OF MEDI-CAL OTHER HEALTH COVERAGE CODES (OHC) AND CODE "F" FOR MEDICARE HEALTH MAINTENANCE ORGANIZATION (HMO).

The purpose of this letter is to inform you of new procedures regarding the assignment of OHC codes. This replaces All County Welfare Directors Letter (ACWDL) No 96-18, which erroneously omitted the word "not" on page two, second paragraph, second sentence. The correction is noted in bold print. Please discard ACWDL No. 96-18 and replace it with this letter.

Medi-Cal Eligibility Procedures Manual, Article 15A, requires county staff to identify health insurance coverage and to enter an OHC code on the Medi-Cal Eligibility Data System (MEDS) at the time eligibility is determined or redetermined, or at any time a beneficiary reports a change in coverage. To simplify assignment of OHC codes, we are reducing the number of OHC indicator codes from the current 33 codes to 8 (see Enclosure 1). This change is in response to concerns county welfare departments have expressed about the large number of OHC codes In addition, OHC Code "F" is being activated to denote Medicare HMO coverage

Reduction of OHC Codes

Effective immediately, counties may begin using the eight OHC indicator codes identified in Enclosure 1. County procedures should be fully implemented by May 3 1, 1996. Counties are not required to change the OHC coding on existing cases. The claims processing and eligibility systems will continue to recognize all 33 codes.

OHC Code "F" - Medicare HMO

Included in the enclosed list of OHC codes is OHC Code "F", denoting coverage through a Medicare HMO. Medicare recipients may elect to enroll in a Medicare HMO in lieu of the usual fee-for-service Medicare coverage. Once enrolled in a Medicare HMO, the Medicare recipient must obtain Medicare covered services from HMO approved providers.

To ensure that Medicare HMO coverage is fully utilized before Medi-Cal payment occurs, the MEDS record of Medi-Cal recipients who have enrolled in a Medicare HMO must be coded with OHC Code "F". As with other insurance coverage identified for new eligibles, a DHS 6155 should be completed and sent to the Department's Health Insurance Section, It should be noted that some Medicare HMOs provide coverage for prescriptions and/or vision care, in addition to the customary Medicare covered sex-vices of hospital, medical, and long-term care It is important that all scopes of coverage available through the HMO be indicated on the DHS 6 155

To identify current Medi-Cal recipients who have already enrolled in a Medicare HMO, the Department will use federal Medicare HMO enrollment files to automatically update MEDS and the Health Insurance System (HIS) data base. Medi-Cal recipients will receive a letter (in English and Spanish), advising them of the MEDS update. (A copy of the recipient notification is enclosed as Enclosure 2). This process is targeted to begin in early 1996 Counties will be notified of specific dates via E-Mail.

The enrollment match will be conducted on a monthly basis for ongoing Medi-Cal recipients as they enroll or disenroll in a Medicare HMO. It is **not** necessary for the counties to submit a DHS 6155 for recipients whose Medicare HMO coverage is identified by the Department. However, it is imperative that a DHS 6155 be completed by the county for new Medi-Cal eligibles enrolled in a Medicare HMO. This ensures that MEDS and HIS are updated with the coverage information from the onset of Medi-Cal eligibility.

In accordance with existing OHC procedures, counties may delete OHC Code "F" from a recipient's MEDS record if the recipient presents a disenrollment confirmation document or signs an affidavit to this effect. Supplemental Security Income/State Supplementary Payment recipients should be referred to the Health Insurance Section's toil-free number, I-800-952-5294

Medi-Cal Eligibility Procedures Manual, Article 15A, will be revised to reflect these policy changes shortly.

If you have any questions regarding this letter, please contact either Chari Hug at (916) 327-0492 or Vicki Partington at (916) 323-9539 or the Health Insurance Section

Sincerely,

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

ENCLOSURE 1

MEDS
OHC INDICATOR CODES
Effective January 1, 1996

I. HMO

K ..... Kaiser
C ..... CHAMPUS Prime HMO
F ..... Medicare HMO
P ..... Any Other PHP/HMO

II. Cost Avoidance

V ..... Any Carrier (other than the above;, includes multiple coverage)

III. Pay and Chase/Post Payment Recovery

A ..... Any Carrier (includes multiple coverage)

IV. Dental Only

L ..... Any Dental Carrier

V. No Coverage

N ..... No Coverage

ATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY T E
DEPARTMENT OF HEALTH SERVICES
THIRD PARTY LIABILITY BRANCH
LTH INSURANCE SECTION
BOX 1287
RAMENTO, CA 95812-1287
916) 523-953-e

ENCLOSURE 2

Eligibility Month.

MEDS-ID :
BKRTHDAY :
O/C
(Name of the health plan is inserted here)

IMPORTANT MEDI-CAL NOTICE

Our records show that you have health coverage through a Medicare Health Maintenance Organization (HMO) as well as Medi-Cal. Beginning with the eligibility month shown above, your Medi-Cal records will be coded to show this Medicare HMO coverage. Your providers will receive this information when they verify your Medi-Cal eligibility.

By law, Medi-Cal cannot pay for medical services covered by your Medicare HMO plan. You will still be able to use your Medi-Cal benefits for Medi-Cal covered services which your Medicare HMO plan does not cover. Medi-Cal till not pay for services you receive from a non-plan provider if you could have received those covered services from a plan provider.

To receive services, first go to your Medicare HMO plan (indicated in the O/C field shown above) to receive health care services. If the plan does not provide a needed service, request a denial letter or Explanation of Benefits (EOB) which clearly states that the requested service is not covered under the terms of the health plan, Give this denial letter or EOB to a Medi-Cal provider who will send it with the **Medi-Cal claim** for reimbursement.

If you do **not** have the Medicare HMO coverage with the plan that is shown, contact your county welfare department. You will be required to submit verification that you no longer have or never had the **coverage** indicated before your records can be changed. This verification should be either a document from the Medicare HMO plan showing the date the policy terminated or a signed affidavit which states that you no longer have, or never had, health coverage with the Medicare HMO plan indicated. Your county welfare department has the affidavit forms. If you are receiving SSI/SSP, call 1-800-952-5294. For TTY/TDD, please call California Relay Services at 1-800-73 S-2929.

California Association of HMOs, Inc.

1201 K Street
Suite 750
Sacramento, CA 95814
(916) 552-2910
FAX (916) 443-1037

August 21, 1996

Mr. Joe A. Kelly, Chief
Medi-Cal Managed Care Division
Department of Health Services
714 'P' Street
P.O. Box 942732
Sacramento, CA 94234-7320

Dear Mr. Kelly:

On Friday, August 9, a task force from the California Association of HMOs met with representatives from the department to discuss problems presented by dual eligibles. Unfortunately, the department representatives scheduled to meet with us were unable to meet with us. The two department representatives who were able to meet with us did an admirable job, but many of the questions were outside their areas of expertise.

On behalf of the CAHMO task force, I am submitting a list of questions that remain unanswered after the meeting. Your response to the CAHMO task force would be appreciated.

Concerns/Questions Raised About Dual Eligibles

- Enclosed is a letter that dual eligibles received from the department's third party liability branch. This letter raised obvious concerns with enrollees. What is the review process for such letter? Plans should be involved in reviewing such letters to ensure the impact on enrollees is limited. CAHMO also requests that plans be notified that such letters are going out so they may be prepared to respond to enrollee questions.

- Please clarify the department's policy regarding dual eligibles who are enrolled in a Medicare-risk plan and wish to be enrolled in a Medi-Cal plan? How is the Medicare-risk plan to be informed about the enrollee's eligibility (or loss thereof) for Medi-Cal? Also, in cases where the enrollee uses his or her FFS Medi-Cal coverage to access out-of-plan providers without referral from his or her Medicare-risk plan, who will be responsible for the payment of those services -- or will payment simply be denied? WAS TOLD THAT POLICY IS THAT MEDICARE HMO ENROLLEES ARE NOT ALLOWED TO ENROLL IN A M-CAL MCP

- There is a problem with the timing of Medicare and Medi-Cal disenrollments that may result in individuals being disenrolled from a plan's Medicare while remaining in the Medi-Cal programs. This causes continuity of care problems and needs further exploration by technical staff. THIS IS A PROBLEM THAT IS NOT RECONCILIABLE AS LONG AS MEDICARE ALLOWS MID-MONTH DER

Concerns/Issues with Mandatory Enrollees

- Children in foster care are voluntary eligibles and should not be auto assigned. However, since some foster children have an AFDC aid code, they were auto assigned in San Diego County. The plans would appreciate getting copies of the State's communications with County welfare departments regarding how they should handle this situation.

- There appears to be a great deal of confusion over enrollment of SSI/SSP recipients. Are these individuals to be a mandatory or voluntary enrollment into Medi-Cal managed care?

- Several plans have asked to use the enrollment contractor's l-800 number in their advertising. They have been told by the department not to use the enrollment contractor's toll-free number because the enrollment contractor is unable to handle the volume of calls. What is being done to increase the enrollment contractor's ability to handle calls? When will health plans be able to advertise the toll-free number?

- The issue was raised about auto assignment (default) of current health plan members. Apparently an enrollee who is a member of a particular health plan may receive the enrollment information and not return the form. These people are being defaulted after 30 days and are not being defaulted to their current health plan. The impact on continuity of care is obvious. What is the department's policy on default enrollments for enrollees who are currently members of a health plan?

- Health plans are not aware of which enrollees have been defaulted into their plan. Can the department provide some sort of notification or special coding for default enrollees?

- What is the department's response to the questions presented in the HCFA Region IX Managed Care Pre-Implementation Review Guide under Section Four, Dual Eligibles (please see attached)?

Thank you in advance for your timely consideration of this request. The task force looks forward to working with you on this issue., If you have any questions, please feel free to contact me at 916-552-2910.

Sincerely,

Mark Sektnan
Legislative Advocate

ELEMENT C: PROVIDER EDUCATION AND TRAINING

Factors to be Evaluated

1. Does the Health Plan have a dedicated provider relations unit? Is the unit adequately staffed to respond to inquiries from providers (e.g., the need for refresher training)?

2. Does the Health Plan have a provider/training manual for use in educating providers/provider groups so that they fully understand the Plan's policies and procedures?

3. Does the State have a method in place to inform Health Plans of changes in policy?

4. Does the Health Plan have a method in place to inform sub-contracting providers of changes in policy?

Methods of Evaluation

1. Interview the Health Plan's provider relations staff.

2. Review the Health Plan's provider training manual. Ascertain whether it contains enough information to educate the providers on the Health Plan's policies and procedures (e.g., prior authorization, fee-for-sezvice (FFS) reimbursement, submission of required reports).

3. Determine the method used by the State, and the Health Plan, to inform providers of changes in policy.

4. Interview several providers/provider groups to determine their perspective on whether they have been adequately informed about the Health Plan's policies and procedures. Identify any problems they have with respect to the HealthPlan's policies, procedures, and operations.

IV. DUAL ELIGIBLES

Individuals who are dually (Medicare/Medicaid) eligible present special challenges to States and Health Plans. Because these individuals already have Medicare coverage, it is incumbent on the State/Health Plan to coordinate the delivery of Medicaid services with the Medicare delivery system chosen by the beneficiary. Such coordination will provide for continuity of care and provide a maximum return for dollars spent. While dually eligible beneficiaries retain the right to receive their services from any Medicare provider of their choice, States/Health Plans are allowed to deny coverage or the Medicare co-insurance/deductible amounts in situations where the individual accesses services outside of their Medicaid Health Plan's network, except in emergency situations.

ELEMENT A

Factors to be Evaluated

1. Does the waiver require that dually eligible (DE) (Medicare/Medicaid) beneficiaries enroll in a Health Plan?

2. If so, what is the State's/Health Plan's method of informing and educating DEs on how to access care, including Medicare benefits, through a Medicaid Health Plan?

3. Does the Health Plan impose any penalties on DEs who choose to obtain care from their Medicare provider, if such provider is not a contracting Medicaid provider (e.g., refusal to pay the Medicare co-insuance/deductible)?

4. How does the State/Health Plan deal with DEs who are also enrolled in a Medicare Health Plan? Has the State/Health Plan developed a special capitation rate for this population?

5. Does the Health Plans' member services or other staff engage in any special activities to deal with the needs of the DE population?

Methods of Evaluation

1. Interview State, Health Plan, and other Contractor staff.

2. Review written materials, including the State's approved waiver contract, and procedures developed by the state, the Health Plans, and the State's/Enrollment Contractor's marketing and enrollment materials.

3. Interview Beneficiary Advocacy Groups to obtain their perspective on the approach taken by the State/Health Plans to provide services to DEs.

V. SPECIAL POPULATIONS AND FEDERALLY QUALIFIED HEALTH CENTERS

Historically, certain providers have traditionally cared for Medicaid beneficiaries. These providers, usually community clinics, Rural Health Clinics, and Federally Qualified Health Centers (FQHCs), are often referred to as "safety net" providers. In addition to caring for the indigent population that has no insurance and does not qualify for Medicaid, these safety net providers are known in communities as providers who will not refuse services to a Medicaid-eligible patient. These providers are often sensitive to the cultural (and linguistic) issues facing Medicaid beneficiaries, as they have close ties to the communities in which they are located. While it is not the responsibility of the State or the Health Plans to protect the safety net, they are required to

State of California Health and Welfare Agency — Pete Wilson, Governc

JUL 18 1996
CLAIMS DEPT.

DEPARTMENT OF HEALTH SERVICES
Third Party Liability Branch
Health Insurance Section
P.O. Box 1287
Sacramento, CA 95811-1287
Toll Free: 1-800-952-5294

July 05, 1996

961980237 1

Eligibility Month: July 1996

MEDS-ID: [redacted]
BIRTHDAY: 08/18/1912
O/C: F 8342
SCAN MEDICARE HMO

[redacted]

RECEIVED
JUL 18 1996
MEDICAL SERVICES

IMPORTANT MEDI-CAL NOTICE

Our records show that you have health coverage through a Medicare Health Maintenance Organization (HMO) as well as Medi-Cal. Beginning with the eligibility month shown above, your Medi-Cal records will be coded to show this Medicare HMO coverage. Your providers will receive this information when they verify your Medi-Cal eligibility.

By law, Medi-Cal cannot pay for medical services covered by your Medicare HMO plan. You will still be able to use your Medi-Cal benefits for Medi-Cal covered services which your Medicare HMO plan does *not* cover. Medi-Cal will not pay for services you receive from a non-planprpvider if you could have received those covered services from a plan provider.

To receive services, first go to your Medicare HMO plan (indicated in the O/C *field* shown above) to receive health care services. If the plan does not provide a needed service, request a denial letter or Explanation of Benefits (EOB) which clearly states that the requested service is not covered under the terms of the health plan. Give this denial letter or EOB to a Medi-Cal provider who will send it with the Medi-Cal claim for reimbursement.

If you do not have the Medicare HMO coverage with the plan that is shown, contact your county welfare department. You will be required to submit verification that you no longer have or never had the coverage indicated before your records can be changed. This verification should be either a document from the Medicare HMO plan showing the date the policy terminated or a signed affidavit which states that you no longer have, or never had, health coverage with the Medicare HMO plan indicated. Your county welfare department has the affidavit forms. If you are receiving SSI/SSP, call 1-800-952-5294. For TTY/TDD, please call California Relay Services at 1-800-735-2929.

Read Carefully HMO Card

MDHP

PERSONAL INJURY UNIT

OVERVIEW

California Department of Health Services
Third Party Liability Branch
Recovery Section'
Revised April 1996

PERSONAL INJURY UNIT: OVERVIEW

The Personal Injury (PI) Unit of the California Department of Health Services (DHS) is responsible for the identification, negotiation, and recovery of Medi-Cal monies in personal injury actions Typical PI actions include, but are not limited to, those which involve the following: auto accidents. medical malpractice, product liability. premises liability, and worker's compensation. The State's right to file and collect on liens in these actions exists when Medi-Cal pays for the treatment of a beneficiary's illness or injury, for which a third party is liable. Sections 14 124.70 through 14 124.79 I of the California Welfare and Institutions (W&I) Code detail the rights and responsibilities of the Department. Medi-Cal beneficiaries. and their attorneys to ensure the proper recovery of Medi-Cal monies The program is also governed by federal Medicaid statutes

The Unit's 50.2 employees are divided into five modules and handle a workload of approximately 20,000 active cases. Collections for fiscal year 94/95 were approximately 28 million dollars. Since July I. 199 1, worker's compensation claims have been administered by contractors who receive a fixed percentage of the amounts they cause to be recovered. Worker's compensation collections for fiscal year 94/95 amounted to approximately 1.5 million dollars.

PI cases are identified through several means. Attdrneys, by law, are required to notify the Department when their client has used Medi-Cal to treat the injury or illness. PI referrals are also received from county welfare agencies, Medi-Cal beneficiaries, insurance companies, and other sources. In addition, automated questionnaires are mailed to beneficiaries when a data match of

provider claims and selected trauma (diagnosis) codes indicate that the nature of the services could relate to a possible PI action. Worker's compensation cases are identified through a data match with the Department of Industrial Relations and the Medi-Cal Eligibility Data System and forwarded to the contractors along with beneficiary claim detail reports.

In January 1993, the PI Unit went online with the Automated Collection Management System (ACMS) to increase the Unit's efficiency and effectiveness in processing PI cases. The system is comprised of 44 online screens and a number of related batch and online processes Employees may conduct the following activities on ACMS:

--Access and update case information

--Review payment histori.. and create itemizations of Medi-Cal paid services

--Prepare and print form letters (100 PI letter formats are presently stored in the database)

--Send form letters (letters will be folded, stuffed, and mailed off-site)

--Record cashiering deposit data

--Post payments and other accounting transactions

--Write case history notes

--Send and receive user-created and system-created ticklers

--Store and retrieve addresses of beneficiaries, attorneys, insurance companies and others

--Assign caseloads by alphabetical breakdowns

--Cross-reference names of beneficiaries, attorneys, and others

--Calculate net lien formula

--Monitor employee case inventory and production

--Create and send monthly repayment bills

--Create tapes for sending offset requests to Franchise Tax Board

--Purge and restore archived cases

--Generate accounting, production, and management reports on monthly, quarterly, semi-annual, and/or annual frequency

When a PI referral is received, the support staff performs research functions, proceeds to set up a case on ACMS, and orders Medi-Cal payment data. The system then forwards the case to the collection representative who reviews payment histories to identify those medical services which are related to the PI action. The sum total of those service payments constitutes the Department's lien amount, i.e., the amount that Medi-Cal has paid to treat the beneficiary for this specific injury. Over the life of the case, the collection representative will continue to update the lien whenever necessary, to communicate in writing and over the phone with the Medi-Cal beneficiary's attorney, and if needed, defense attorneys, insurance claims adjustors, judges, or anyone who may be a party to or have an interest in the case. When the case reaches a settlement, the collection representative, with the aid of ACMS, computes the net lien based on W&I Code Sections 14124.72(d) or 14124.75, whichever is less.

The "25 percent rule", W&I Code Section 14124,72(d), states that when some form of action is taken by a beneficiary through an attorney and the State seeks reimbursement, the State must reduce its gross lien claim by 25 percent, which represents the Director's reasonable share of attorney's fees paid

by the beneficiary. It must be further reduced by a pro rata share of any litigation costs which must be borne by the beneficiary These deductions are in the nature of a contribution for the fees and costs incurred by the beneficiary and not additional payments to the attorney. The statutes contemplate that attorneys will obtain the full amount of their fees and litigation costs from the gross settlement or judgment. The lien reductions, in recognition of these charges against the gross recovery. inure solely to the benefit of the beneficiarv.

The State will accept 75 percent of any lien claim asserted in tort actions in full satisfaction of it without further verification of the fee actually charged. However, before a pro rata share of the litigation costs will be deducted, the attorney must submit an accounting of these charges This pro rata share of cost is computed by multiplying the ratio of the gross lien claim to the gross judgment or settlement by the litigation costs.

The right to reduce the lien claim by 25 percent in recognition of attorney's fees and pro rata share of litigation costs exists only when the beneficiary personally incurs a responsibility to pay them Thus, in administrative worker's compensation actions where attorney's fees and costs are awarded directly to the claimant's attorney, no reduction in the lien claim is allowed. Also, a reduction does not apply to a Medical Payments (Med-Pay) portion of a settlement since Med-Pay is to be used for repaying medical bills.

The "50 percent rule", W&I Code Section 14124.78, states that the Medi-Cal claim for reimbursement may never exceed one-half of the net recovery to the beneficiary. The "net recovery"

is that which remains of the settlement after deducting the attorney's fees, itemized litigation costs, and itemized medical expenses relating to the injuries paid by the beneficiary. For example, Medi-Cal has paid $30,000.00 for injury-related services, but there is only a $15,000.00 gross settlement negotiated If a contingent attorney fee of one-third ($5,000.00) is charged and costs were $1,000.00, it would leave a net settlement of $9.000 00. Medi-Cal would be limited to one-half of the net settlement, or $4,500.00 (Note: This $4,500.00 for Medi-Cal is not subject to any further reduction for "attorney fee"): If a portion of the medical expenses is paid by private insurance or publicly funded health benefit program, those payments may not be used to reduce the gross settlement or judgment. Only those services for which the beneficiary is legally liable and which he or she actually pays prior to settlement may be deducted. (Note: If Medi-Cal has paid for any portion of these services, no deduction is allowed.)

In addition to the statutorily mandated reductions, further compromise of the State's Medi-Cal claim may be made on a case-by-case basis. If payment of the maximum allowable lien claim would result in undue hardship on the beneficiary, the lien claim may be further reduced at the discretion of the Director (W&I Code- Section 14124.71(b)). Such a reduction would have to be justified by the submission of medical reports and any other pertinent documentation which tend to establish undue hardship.

Authority to make reductions below those prescribed in W&I Code Sections 14124.72(d) and 14124.78 is vested solely with the Director of the Department and his/her delegates. The court or administrative tribunal having jurisdiction over the action does not have authority to order lien

reductions without the Director's consent

When the beneficiary and his/her attorney neglect or refuse to satisfy the Medi-Cal lien. the PI Unit will institute a referral to the Attorney General's office. a referral to the State Bar, a tax return offset by the Franchise Tax Board, or other methods of involuntary collection.

One module in the Unit handles specialized cases involving special needs trusts, risk management, and catastrophic accidents. As needed. this module conducts training sessions and informational seminars for law firm, insurance companies, and others to effect compliance with Medi-Cal personal injury statutes. Also, the module is responsible for ongoing liaison with managed care plans and related Departmental staff to address reporting problems, usability of payment data, and other issues. Staff in this module also write proposed legislation, bill analyses, Requests for Proposals (RFP), and requests for legal opinions. In addition, this module works on special projects to improve and enhance Unit operations. Recent projects include the development of a call management system,' oversight of collection representative and program technician committees to update written procedures; development of a resource library, and development of a website on the World Wide Web

MEDI-CAL LIEN CLAIMS IN PERSONAL INJURY ACTIONS

An attorney seeking to recover against a liable third party for a client who has received health care benefits under the California Medical Assistance Act (Medi-Cal) must consider the rights of the State to be reimbursed. Under current law, the State has a right to assert a lien or claim against any recovery obtained by a Medi-Cal recipient against a liable third party or any and all settlements received for an injury.

Sections 14124.70 through 14124.791 of the Welfare and Institutions Code (W&IC) detail the State's right to assert a claim, intervene, file a lien, or file an independent action where Medi-Cal benefits have been extended to a recipient as a result Of an injury Or illness for which some third party is liable. Since the most common method used by the State to recoup Medi-Cal benefits is the filing Of a lien Or claim, this review is limited to a discussion of the rights and responsibilities of attorneys, their clients, and the State where Medi-Cal claims are involved.

The State's right to seek reimbursement under a lien claim exists in many kinds of actions. A lien claim may be made, for example, in a malpractice action, against an uninsured motorist recovery (W&IC Sections 14124.70(a) and 14124.71) in a worker's compensation case (W&IC Sections 14124.73 and 14124.74) and in a wrongful death action (W&IC Section 14124,72(c)). It is not necessary that the amount of the State's lien claim be asserted or recovered as an item of special damages in order for recovery to be made under it; if a lien claim is property asserted, it attaches to the entire judgment award, or settlement regardless of the allocation of damages (W&IC Sections 14124.74(a) and 14124.78).

Generally, notice of the statutory Medi-Cal lien is given by the filing of a Notice of Lien in the action. However, W&IC Sections 14124.70 - 14124.791 make it clear that the lien arises by operation of law, and that the State also has a right to assert a claim for Medi-Cal benefits provided, whether or not a complaint or formal action has been filed. Thus the term "Lien claim" used throughout this article includes both formal liens and those claims for reimbursement made in cases where no formal action has been actually initiated.

NOTICES

When a complaint or Workers Compensation claim is filed against an allegedly liable third party, notice must be given to the Director of the Department of Health Services within 30 days of the filing of the action (W&IC Section 14124.73). Also, before a judgment, award, or settlement in any action or claim may be satisfied, notices must be given which would give the Director a "reasonable opportunity to perfect and satisfy his lien" (W&IC Sections 14124.76 and 14124.79). Since, as mentioned earlier, the Medical lien claim attaches whether or not suit has been filed, notices must be given whenever a suit or claim has been filed, whenever final settlement of a suit or claim is contemplated, or whenever there is final settlement of a claim without suit or administrative adjudication. A settlement negotiated without notice to the Director could be set aside as being violative of W&IC Section 14124.76.

Responsibility for giving the notices rests both with the recipient and his/her attorney or personal representative (W&IC Section 14124.79). Should the State's right to seek reimbursement be frustrated by failure to give the specified notices, the recipient and his/her attorney could be held jointly liable for the breach of the duty to give notice.

Attorneys should determine if their clients have had any part of their medical expenses paid by the Medi-Cal Program. All notices for personal injury cases, induding medical malpractice, uninsured motorist, emotional distress, wrongful death, etc., should be sent to the Department of Health Services. All Worker's Compensation notices should be sent to Boehm & Associates. Notices should be sent to:

Personal Injury Cases
Department of Heatth Services
Recovery Section/Personal Injury Unit
P.O. Box 2471
Sacramento, CA 95842-2471
(916)323-4836

WCAB Cases'
Boehm & Associates
ATTN: Rhondee Jacopetti
1321 Harbor Bay Parkway, Ste. 250
Alameda, CA 94501
(510) 865-0544

All notices should contain the following information:

1 Medi-Cal recipient's name. If a minor, the parents' or guardians' names should also be given.

2 The Medi-Cal Identification Number(s) (example: 19-20-2001346-011). They may be obtained from the Medi-Cal card or perhaps from medical bills which have been paid by Medi-Cal. All numbers must be reported; a recipient may have had more than one number if the county of residence or the aid category changed.

3 Social Security Account (SSA) Number.

4 Date of birth.

5 Date of injury.

6 Name and address of treating providers of health care and dates of service.

If a complaint has been filed, the case name, court in which it was filed,' docket number, defendants name and address, and defendant's attorneys name and address should be provided. Much of this information can be provided by forwarding a copy Of the complaint.

AGENDA

THIRD PARTY LIABILITY (TPL) AND MANAGED CARE

INTRODUCTION AND OVERVIEW

Susan Shafer, Health Insurance Section
(Profs ID SSHAFER - 323-1974)

TPL TRAINING FOR MANAGED CARE HEALTH PLANS

Susan Shafer

HIPP/EGHP State Administered Programs

Terry Baker, HIPP/EGHP Program
(Profs ID TBAKER - 323-5699)

THIRD PARTY TORT LIABILITY

Anne Clemens, Personal Injury Unit
(Profs ID ACLEMENS - 323-1984)
Valerie Campoy, Personal Injury Unit
(Profs ID VCAMPOY - 323-0168)

WATS Line l-800-952-5294
General Information Line l-800-952-5253

TPL BRANCH ACTIVITIES

HEALTH INSURANCE SECTION:

Health Insurance Identification

Health Insurance Cost Avoidance

Health Insurance Recovery

Premium Payment Unit
(includes HIPP/EGHP Program
and Medicare Buy-In)

RECOVERY SECTION:

Personal Injury

Estate Recovery/Probate

Overpayments

TYPICAL CONTRACT LANGUAGE PERTAINING TO THIRD PARTY LIABILITY, OTHER HEALTH INSURANCE COVERAGE:

***SECTION: RECOVERY FROM OTHER SOURCES OR PROVIDERS

Make reasonable efforts to recover the value of covered services rendered to members whenever the members are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to a private group or indemnification program, but excluding instances of the tort liability of a third party. **Such 'monies recovered are retained by the Contractor*****

Examples - Medicare Coverage
Health Insurance Coverage such as:

- **Champus**
- **Insurance available thru an absent parent**
- **Medicare Supplemental coverage**
- **Prescription only policies**
- **Hospital Inpatient only coverage**
- **Medical services outpatient coverage**
- **Insurance available thru a labor union, employer group health plan, etc.**
- **Major medical only policies**
- **Vision Care**

TYPICAL CONTRACT LANGUAGE PERTAINING TO THIRD PARTY TORT LIABILITY:

*** SECTION: THIRD-PARTY TORT LIABILITY

Make no claim for recovery of the value of covered services rendered to a member when such recovery would result from an action involving the tort liability of a third party or casualty liability insurance including Workers' Compensation awards and uninsured motorists coverage. **The C&tractor will identify and notify the Department** of cases in which an action by the Medi-Cal recipient involving the tort or Workers' Compensation liability of a third party could result in recovery by the recipient of funds to which the Department has lien rights under Article 3.5., part 3, Division 9, Welfare and Insitutitions Code. Such cases will be referred to the Department within 10 days of discovery. To assist the Department in exercising its responsibility for such recoveries, Contractor will met the following requirements: * * *

Example Cases Involve:

Auto Accidents
Slip-and-falls
Worker's Compensation
Wrongful Death suits
Medical Malpractice.. .
Product Liability
Uninsured Motorist Claims

TERMS:

PAYOR OF LAST RESORT: The Department of Health Services is responsible for ensuring that Medi-Cal is the payor of last resort for medical care used by Medi-Cal eligibles in accordance with State Statute Welfare and Institutions Code Section 14 124.90 and Federal Law (Section 1902(a)(25) of the Social Security Act). State laws (Welfare and Institutions Code, Section 10020, 14000, 14003, 14005, 14016.3 and 14024) require Medi-Cal beneficiaries to report and utilize these resources before using Medi-Cal. In instances where Medi-Cal has paid for a beneficiary's medical care first, these laws also require the program to seek reimbursement from the responsible third party.

THIRD PARTY LIABILITY (TPL): An individual or entity that is liable to pay all or part of the medical cost of injury, disease, or disability of a benficiary. The responsibility of insurers for payment of claims which are connected with injuries or trauma sustained by recipients. This may be contractual, a legal obligation or as a result of or the fault or negligence of such third parties (e.g. auto accidents or other personal injury casualty claims or work compensation appeals).

OTHER HEALTH INSURANCE COVERAGE (OHC): Benefits for health related services or entitlements for which a Medi-Cal beneficiary is eligible under any private, group, or indemnification insurance program, under any other State or federal medical care program, or under other contractual or legal entitlement.

COST AVOIDANCE: Requiring providers to bill other health insurance carriers before submitting claims to Medi-Cal. It is the process of utilizing other insurance assets before billing Medi-Cal.

POST PAYMENT RECOVERY OR PAY-AND-CHASE: A process to recoup monies which have been paid for a Medi-Cal beneficiary when that beneficiary was covered for that service by a liable third party.

COORDINATION OF BENEFITS: The process of utilizing third party libility resources to ensure that the Medi-Cal Program is the payor of last resort. This is accomplished by either operating a cost avoidance method of paying claims when the existence of Medicare or private health insurance is known at the time the claim is processed, or the method of post payment recovery of the cost of services if coverage is identified retroactively.

Who manages Third Party Liability when a State contracts its Medicaid Program to Managed Care Plans?

Barbara V. Carr

Managed care is becoming the delivery of system choice in state Medicaid programs. In designing such a system, many states do not give measured consideration to assigning the administrative tasks of third party liability (TPL) identification and utilization. Because TPL produces significant savings for Medicaid (without TPL savings, California's Medicaid costs would be over 20% higher), and because these savings can erode rapidly if TPL tasks are not performed effectively, the decision making should be done with deliberation. There are, however,' many complex decisions to make, since TPL comprises many separate tasks that *can be performed by the state, by* a *TPL contractor, or by managed care plans, and since a variety of factors must be considered in* assigning each.

Background

Many state Medicaid programs are turning to managed care plans to aid in providing access and preventive care to Medicaid beneficiaries as well as to control costs in the longer run. An operational question arises when this occurs: Who manages Third Party Liability (TPL)? The term TPL as used here refers to the sum of activities for causing beneficiaries with any legal

entitlement to health care to utilize this entitlement. before obligating Medicaid, but also includes estate recovery.

In the more traditional fee for service (FFS) setting, the state typically either carries out all TPL activities or contracts for some of them on a statewide or regional basis. With managed care, more options are available. In the rush of moving to managed care, however, states do not always clearly delineate these options and make informed decisions, considering all relevant factors. The decision is, therefore, often made by default and may not be the decision that best assures maximum savings from TPL, optimal usage of managed care, and full compliance with federal requirements.

In a recent TPL/MMIS Conference, HCFA staff indicated that there was likely to be no federal mandate to prescribe a single approach to the utilization of TPL in a managed care environment. Instead, a variety of options would be available. From the federal perspective, responsibility for utilizing TPL could be delegated to the provider, the plan, or-retained-as long as the choice was reflected in plan rates.

Perhaps the most significant next question, becomes: Who cares? Why is it important that informed decisions be made? Federal mandate aside, the answer lies in the numbers.

For 1993/4, California's Medicaid expenditures were $15.1 billion, reflecting some $3.2 billion in net savings (premium costs are offset) from measurable cost avoidance and recovery of TPL (a portion of cost avoidance savings cannot be measured because no claim is submitted to Medicaid; this includes, for example, Medicare or private HMO coverage or any service fully paid by health insurance). The largest portion of this savings figure is attributable to Medicare. It excludes provider and beneficiary collections for fraud, audit exceptions and utilization disallowances. In addition, while capitation payments are reflected in the expenditure figure, TPL savings within existing capitated plans are not reflected in the savings figure.

This means that, without effective TPL identification and utilization, California would have expended well over 20% more on its Medicaid program than it did. This number is significant enough to merit any Medicaid Director's attention, because unconsidered decisions can lead to rapid erosion of these savings.

This paper attempts to lay out what the TPL functions are and to identify factors to be considered in deciding who should carry them out. No attempt is made

to recommend a best course of action, since that best course would be highly dependent upon each state's individual situation.

TPL Functions

Identification

First, the availability of a third party payor for a particular Medicaid beneficiary and/or service must be identified. Major payors to be considered include Medicare, health insurance, private HMO coverage, a personal injury lawsuit, workers compensation, and, after death, the beneficiary's estate:

Medicare: Identification is made both by intake worker and by file matches with Social' Security Administration. -Generally, the more highly automated file match is the most accurate source of information. Matches may also be made to determine which Medicare eligibles are enrolled in Medicare HMOs. Medicare eligibility information is typically stored on the state's centralized Medicaid eligibility file, from which it is used to notify providers of coverage, for cost avoiding Medicaid claims and in post payment recovery activities.

Health Insurance: Identification is made by intake workers, child support case workers, file matches with health insurance carriers, reporting by Medicaid providers, and various mailings to Medicaid beneficiaries and employers. Health insurance information is often stored on the state's centralized Medicaid eligibility file, from which it is used to notify providers of coverage, for cost avoiding Medicaid claims and in post payment recovery activities.

Private HMO coverage: Identification is made by intake workers, child support case workers, file matches with private HMOs, and various mailings to Medicaid beneficiaries and employers. Private HMO information is often stored on the state's centralized Medicaid eligibility file, from which it is used to notify providers of coverage and for cost avoiding Medicaid claims. Provider notification is especially important here, since HMOs will not pay for any but emergency services provided by non-plan providers.

Personal injury Lawsuit: Identification is made by beneficiary mailings following trauma code edits on paid claims data, by attorney reporting, and by case worker reporting.

Workers Compensation: Identification is made by file match with workers compensation appeals boards and by case worker reporting.

Beneficiary Estate Recovery: identification is made by attorney reporting of probate, mailings to heirs or responsible parties following death reporting on the eligibility file or in a provider claim, or following other investigative techniques.

Premium Payment

States purchase health coverage to use as TPL from two sources: 1. Medicare 2. Health insurance or private HMOs.

Medicare: States routinely pay Medicare Part B premiums (Buy-In) for Medicaid eligibles who are also eligible for Medicare. In some cases, states pay Medicare Part A 'premiums as well.

Health Insurance and Private HMOs: Under the Employer Group Health Plan mandate, States must pay private health coverage premiums when it is cost effective to do so.

Cost Avoidance

When probable TPL is known to exist at the time a claim is submitted, the cost avoidance methodology must be exercised unless the service is excluded in law or federally waived based on cost effectiveness. Under this methodology, providers must bill the Third Party and receive payment or denial before billing Medicaid: The Medicaid claims processor must deny claims that have not been properly billed to the TPL and reduce Medicaid payments by any TPL payment. This methodology is used with **Medicare, health insurance, and private HMOs.**

Post Payment Recovery

When cost avoidance is federally excluded (child support cases and prenatal and preventive pediatric services; these exclusions were enacted to insure access to medical care), waived '(because it is not cost effective), or not possible because the TPL was retroactively identified or does not have a clear liability at the time of claim payment, the state must use the third party resource by post payment recovery (also called the pay and chase method). In this process, payments made on behalf of a beneficiary from all Medicaid payment sources (FFS system', managed care plans, premium payments) must

be itemized and billed to the third party payor or, in some cases, back to the Medicaid provider who is instructed to bill the third party payor. This methodology is used with **Medicare, health insurance, personal injury cases, workers compensation,** and **estate recovery.**

Considerations for Assignment of Functions

Assignment of functions must address several questions: Should beneficiaries with known TPL be enrolled in managed care or excluded? Who can most efficiently do the TPL work, the state or plan(s)? Can it be done most effectively in a central setting or in a decentralized mode? Should TPL be utiiized by cost avoidance or recovery? Who should receive TPL savings?

Combinations and Permutations

In a straw poll of states conducted at a recent TPL/MMIS conference, it appeared that there were three basic models of the private heatth coverage and managed care plan relationship, designated by a state that presented each:

Oregon: Eligibles with any private insurance coverage are. excluded from enrollment in managed care plans; TPL activities are retained by the State.

Washington: Eligibles with private insurance coverage are enrolled in managed care plans; TPL utilization is delegated to the plans.

Missouri: Eligibles with private insurance coverage are enrolled in managed care plans; TPL activities are retained by the state.

A myriad of variations exists, however. Each of the functions and many of the subfunctions described above may therefore be considered as separate activities that may be assigned to the managed care plans by contract or retained at the state level to be performed by state employees or contracted out separately. Eligibles with TPL may be enrolled in or excluded from managed care plans. The decisions may differ among managedcare plans, based on

plan option, **plan** performance, or plan tenure. Different decisions may even be made for different service types or different types of TPL.

Factors that should be considered in deciding whether to enroll eligibles with TPL in managed care plans and who should perform TPL activities include:

Economies of Scale

Some tasks can be completed more efficiently and accurately in a central setting or computerized file rather than by several different entities or in a number of files. Examples include receiving reports of health coverage, personal injury lawsuits, work-related injury or death; maintaining a file of insured or Medicare-covered eligibles or of current health insurance carriers; performing computerized file matches to identify covered eligibles or paying health insurance or Medicare premiums. The cost of establishing and operating duplicate systems to perform these tasks could be prohibitive.

In addition, in a central setting, system maintenance is easier and less expensive and policy changes can be more readily and accurately implemented. A central operation lends itself to monitoring or auditing at lower cost. A central setting can also minimize the TPL cases that "fall through the cracks" because of a beneficiary moving, for example, from one county or plan to another, or moving in and out of the fee for service system.

Interfaces Required

Certain TPL tasks require interface with an outside organization (SSA for Medicare identification, health insurance carriers or private HMOs for enrollment matches). These outside organizations might not welcome the opportunity to perform tbe same interface with a number of organizations in any one state. In addition, if the interfaces are numerous, such as attorneys for personal injury suit or probate reporting, confusion about whom to notify could result in reporting delays and lost savings. If the interfaces are internal to Medicaid (eg obtaining encounter data from the Fee for Service and Premium Payment systems as well as other plans, to produce a complete expenditure record), the cost of multiple interfaces must be considered.

Encounter Data

Neither the state nor a plan can carry out post payment recovery activities without accurate, timely and complete encounter data. Without this data, it is impossible to perform the activity and extremely difficult to monitor the

plan's performance of TPL functions. Encounter data is essential to effective utilization of TPL and must include TPL data elements.

Alternatives Available and their Effectiveness

Consideration must be given to whether the managed care plans have a desire to, the capability of, experience in and funding to invest in a system for utilizing TPL. Some states have found plans unwilling or unable to carry out utilization activities, even when they were contracted to do them. Others found plans interested, highly motivated and experienced in carrying out TPL activities. In some cases, a managed care plan may be willing to do TPL, but unable to develop a system for utilizing it within the time frames of an initial contract.

Some aspects, of TPL are not conducive to alternate use. Medicare Part A, for example cannot be postpayment billed by the state or a plan. O'nly providers may bill this coverage, and not every 'managed care plan qualifies as a provider. Private pharmacy coverage cannot be effectively billed by anyone other than the provider. For these coverages, then, cost avoidance is essential and only the claims processor can carry out cost avoidance. Any post payment recovery must be carried out through the provider.

Managed care plans cannot reasonably utilize private or Medicare' HMO coverage, except by denying service to enrolled eligible and redirecting the patient to the other HMO.

State Law

State law may dictate who may carry out what tasks and to what extent they may be delegated. In addition, the question of the state's subrogated rights to third party coverage being further subrogated to a managed care plan rnust be considered.

Staff to do versus Staff to monitor

If a state fully delegates TPL to managed care plans, it must still monitor plan performance to assure maximum savings and federal compliance. If the state contracts with numerous plans, a significant number of monitoring staff may be required. Those managing the managed care contracts are not typically allocated enough time to monitor TPL utilization in addition to contract compliance issues such as access and quality of care.

Need to Maximize Managed Care Enrollment

To the extent a State wishes to enroll all or almost all of its eligibles in managed care, exclusion of some or all eligibles with TPL mitigates against this goal. Exclusion of eligibles with certain types of TPL can also limit their access to care, receipt of preventive care, and case management.

Beneficiary Self-Sufficiency

Allowing a beneficiary to use his or her own insurance or Medicare coverage up front, through provider billing, may remove some of the stigma of receiving medical care through the "welfare" system, even if that coverage must be purchased **or** supplemented by Medicaid. It may also allow access to a greater variety of medical providers.

Admiriistrative Complexity

Complexity can be created, for example, by the need to enroll and disenroll eligibles from managed care as their TPL status changes. Complexity may also result when a provider is paid on a capitated basis, but must bill TPL on a service or encounter basis.

Labor Intensity

Some TPL tasks are extremely labor intensive and, as such, might not be attractive to managed care plans. These include, for example, premium payment and appeal of TPL denials of payment.

Proximity to Beneficiary

Some tasks can best be carried out by the entity that actually sees the beneficiary. These may include identification of health coverage, identification of potential health insurance premium payment cases, identification of potential personal injury or workers compensation cases, and death reporting.

Fiscal Considerations

These are many:

1. If TPL activities are delegated to the plans, capitation rates must be adjusted to assume utilization. Failure to utilize fully should be identified and documented so that, several years down the road, when the plan seeks higher

rates or rates based on the plan's own experience, this failure is not ignored. Without such a system, TPL savings will erode over time and managed care rates wi l l escalate.

2. Duplicate payment for medical care should be avoided. This means a managed care enrollee should not also be enrolled in the state's Health insurance Premium Payment plan, and vice versa. If a state is paying Medicare premiums for an eligible, the cost/benefit of also enrolling that person in managed care must be carefully considered. Enrollment of an eligible with private or Medicare HMO coverage in managed care could be viewed as a waste of the managed care premium. Enrollment of an eligible with comprehensive health insurance coverage in managed care should be scrutinized carefully for cost/benefit. In each case, the value added by purchase of the second coverage should be at least equivalent to the purchase price.

3. Assignment of responsibility for a TPL task should consider who will benefit financially from the task. For example, if a managed care plan is assigned to identify and refer personal injury cases to the state for collection and the plan receives no share of that collection, the plan does not have strong motivation to carry the task out. Realistically, plans must have a fiscal incentive to complete the tasks they are assigned.

4. Premium reduction to reflect FFS performance in the TPL arena may not be enough of an incentive for the plans, if they do not perceive the cost/benefit of the activities to be to their advantage.

5. There is a cost associated with developing and operating a system to utilize TPL. Plans may not be willing or able to make the investment that will ensure the return-or may not have faith that the return is a sure one. Or, plans may be willing, but not able to develop a system within the contractual period available.

6. On the other hand, if the state retains TPL functions, it also retains the cost of carrying these out, rather than delegating that cost to the plans. State costs may even increase, because encounter data must be gathered from multiple sources.

7. If the state or plan carries out post payment billing activities rather than allowing the provider to utilize coverage by direct billing, providers may suffer financially. That is, they may collect less in plan capitation or FFS payments than they could get from Medicare, health insurance, or a personal injury lawsuit.

Conclusions

Unfortunately, this is an incredibly complex subject, which cannot easily be presented and explained to policy makers and legislators. This complexity can contribute to hurried and unschooled judgments. In the rush of negotiating the various critical program aspects of managed care (staffing ratios, quality of care, enrollment methodologies, access, handling of beneficiary complaints, capitation rate calculation), it is easy to ignore the seemingly minor administrative task of TPL utilization. The dollar value of TPL, however, argues for making its consideration a high priority when designing managed care use in a state's Medicaid program.

Each state's TPL/managed care decisions will undoubtedly differ from those of other states and an individual state's decisions may change over time, but the compt'exity of each decision must be recognized so all factors affecting it may be considered. And, in managed care implementation, clear assignment of responsibility must be made of every TPL function.

March 1995

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY

PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES

714/744 P STREET
P. 0. Box 942732
SACRAMENTO, CA 94234-7320

(916) 654-8076

December 10, 1996

MMCD Letter No. 96-17

TO:

[X] Prepaid Health Plans, Including Local Initiatives, Commercial Plans, and Geographic Managed Care Plans

[X] Primary Care Case Management Plans

[X] County Organized Health Systems

SUBJECT: REPORTING RESPONSIBILITIES REGARDING THIRD PARTY TORT LIABILITY/ESTATE RECOVERY

Purpose

This letter is being issued to clarify the reporting responsibilities of Medi-Cal managed care plan (MCP) contractors in the matter of Third Party Liability (TPL) torts and estate recovery. This letter replaces COB Letter 88-l 1, dated May 23, 1988.

Denartment Recovery Rights

The Department of Health Services retains lien/claim rights in TPL tort and estate actions involving Medi-Cal members. In some cases, the first notice a contractor will receive of an estate claim or an action by a Medi-Cal beneficiary involving the tort liability of a third party will be from the Department (or Boehm and Associates, a contractor acting on behalf of the Department in workers' compensation cases). The Department will request an itemization of medical services provided to a MCP member. The contractor is responsible for forwarding to the Department within 10 to 30 days an itemized list of ALL services for the periods requested.

Contractor Responsibilities Regarding Tort Liabilitv

All Medi-Cal managed care contracts require that contractors identify and notify the Department within ten days of the discovery of cases in which an action by the Medi-Cal beneficiary involving the tort liability of a third party could..result in recovery by the recipient of funds to which the Department has lien rights under Article 3.5, Part 3, Division 9 of the Welfare and Institutions Code. Tort liability may include, but is not limited to, incidents such as auto accidents, slip-and-falls, medical malpractice, product liability, premises liability, and workers' compensation actions.

Upon rendering services in a possible TPL tort situation, each plan contractor shall compile the following information by direct questioning of the injured member or his/her parent, spouse, and/or guardian:

1) Member Name
2) Address
3) Social Security number
4) Telephone Number
5) Date of Injury
6) Attorney Name, Address, and Telephone Number (if any)
7) Insurance Company Name, Address, and Telephone Number (if any)

Upon ascertaining these facts, the contractor must prepare an itemized list of ALL services provided to the individual from the date of injury forward. The list must include out-of-plan services paid by the plan. The itemized list must include for each service:

1) Date(s) of Service
2) Provider Name (if different from contractor)
3) Diagnosis Code
4) Procedure Description/Procedure Code
5) Value of Service (usual customary and reasonable charge made to the general public)
6) Date of Denial and Reasons (if applicable)
7) Me&-Cal Allowable Amount (if available)
8) Amount billed by a subcontractor or out-of plan provider to contractor (if applicable)
9) Amount and Date Paid by Contractor to Subcontractor or Out-of-Plan Provider (if applicable)

If treatment is of a continuing nature, the contractor must note this in the comments portion on the itemization and update this information as necessary. This information is required pursuant to the terms of the plan contract and California Code of Regulations, Title 22, § 53862 and § 53861. (The formats for the submission of the required data are enclosed, Attachments I and II.) After compilation, reports are to be mailed to:

Department of Health Services
Personal Injury Unit
P.O. Box 2471
Sacramento, CA 95812-2471

(Workers' Compensation Only)
Boehm and Associates
P.O. Box K
Alameda, CA 94501

In the event a plan contractor is contacted by a member, his/her attorney, or a casualty insurance carrier requesting an itemization for a tort liability action, the contractor shall direct these individuals to the Department's Personal Injury Unit. (A proposed letter to respond in these situations is enclosed, Enclosure III.) Plan contractors shall provide the Department's Personal Injury Unit with a copy of any requests by subpoena and any documents released as a result. Questions relating to specific information requirements should be directed to Anne Clemens, Personal Injury Unit, at (916) 323-1984.

Contractors Do Not Have Third Party Tort Liability Recovery Rights

The terms of the managed care plan contracts specifically limit contractors from attempting recoveries relating to an action involving tort liability of a third party or casualty liability insurance, including Workmen's Compensation awards and uninsured motorists coverage. Additionally, California Code of Regulations, Title 22, § 53866 does not permit plan contractors to attempt recovery in third party tort liability circumstances. Accordingly, contractors are required only to comply with the contractual reporting requirements described in this letter.

If you have any questions regarding your contractual responsibility to report TPL situations, please contact your contract manager.

Sincerely,

Joseph A. Kelly, Chief
Medi-Cal Managed Care Division

Enclosures

bcc: Ann-Louise Kuhns
Assistant Chief
Medi-Cal Managed Care Division
8/650

Mary Fermazin, M.D., MPA,
Chief
Policy and Quality Improvement
Branch
8/650

Alan Stolmack, Chief
Policy Support and Development
Section
8/650

Lisa Tanaka, Chief
Policy Unit
8/640

Vickie Orlich, Chief
Financial Unit
1801 7th Street

Anne Clemens
Payment Systems Division
Personal Injury Unit
591 North 7th Street, 2nd Floor

JH: sdw

PSDS# 3155

Author: Janice Harris
Senior Policy Advisor
Policy Unit
8/650 7-3031

Division: Joseph A. Kelly, Chief
Medi-Cal Managed Care
8/650 4-8070

WP 6.0 W:\CLERICAL\PSDS\3RDPRTY2.TRT

Attachment I

Send To: Department of Health Services
Personal Injury Unit
P.O. Box 2471
Sacramento, CA 958 12-247 1

Plan Name _____

POTENTIAL THIRD PARTY LIABILITY NOTIFICATION

COMPLETE THIS FORM ONLY WHEN MEDI-CAL MANAGED CARE WAS USED OR WILL BE USED FOR THIS INJURY AND ONE OF THE FOLLOWING APPLY

1. The third party has liability insurance.

2. The beneficiary has filed or intends to file a claim orlawsuit.

1. Injured Person (include AKA's)		
Date of Injury	Social Security Number	Date of Birth
2. Additional Injured Person		
Additional Injured Person		
3. Injured's Attorney/Name of Firm		Telephone Number
Address (Number and Street)	City	State ZIP Code
4. Third Party Liability Insurance Company		Adjuster's Name/Telephone Number
Address (Number and Street)	City	State ZIP Code
Claim/Policy Number/Policyholder's Name		
5. Injured's Insurance Company		Adjuster's Name/Telephone Number
Address (Number and Street)	City	State ZIP Code
Claim/Policy Number/Policyholder's Name		
6. Person Providing Information	Telephone Number	Date Completed

Attachment II

PLANNAME:

PREPARED BY:

PHONENUMBER:

ADDRESS:

DATE:

PATIENT NAME:

SSN:

DATEOFBIRTH:

PROVIDER OF SERVICE (**INDICATE** IF CAPITATED)	D O S	I C D '9	**PROC** CODE	**AMT** BILLED	AMT PAID	MEDI-CAL ALLOWABLE*	VALUE OF SERVICE	DENIAL DATE/REASON FOR DENIAL

Comments:

*If available

To: Department of Health Services
Personal Injury Unit
P.O. Box 2471
Sacramento, CA 95812-2471

Attachment III

To: Attorney or Insurance Carrier

Date: _____

Re: _____

Date of Injury: _____

This is in response to your request for a medical report and/or an itemized bill in connection with medical care of the injury sustained by the above-named patient, who is a member under California's Medi-Cal Managed Care Program. The Department of Health Services, Personal Injury Unit, may have recovery rights in a personal injury action.

If you desire an itemized bill, please contact the following office by mail:

Department of Health Services
Personal Injury Unit
P.O. Box 2471
Sacramento, CA 95812-2471

You may also call the Personal Injury Unit at (916) 3234836.

Sincerely,

Health Plan: _____

By: _____

cc: Department of Health Services
Personal Injury Unit
P.O. Box 2471
Sacramento, CA 95812-2471

(When cc'ing the Personal Injury Unit, please include information required on Enclosures I and II, if not already forwarded.)